

A New Approach
To Old Diseases

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PHLEBITIS REVEALED

"Phlebitis is the root of all diseases"

Cruveilhier (1829)

By OTTO MEYER *M. D.*

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Phlebitis Is the Root of All Diseases.

JEAN BAPTISTE CRUVEILHIER
1829

“Do you know that many patients who suffer from various diseases really have Phlebitis, — but are ignorant of it?”

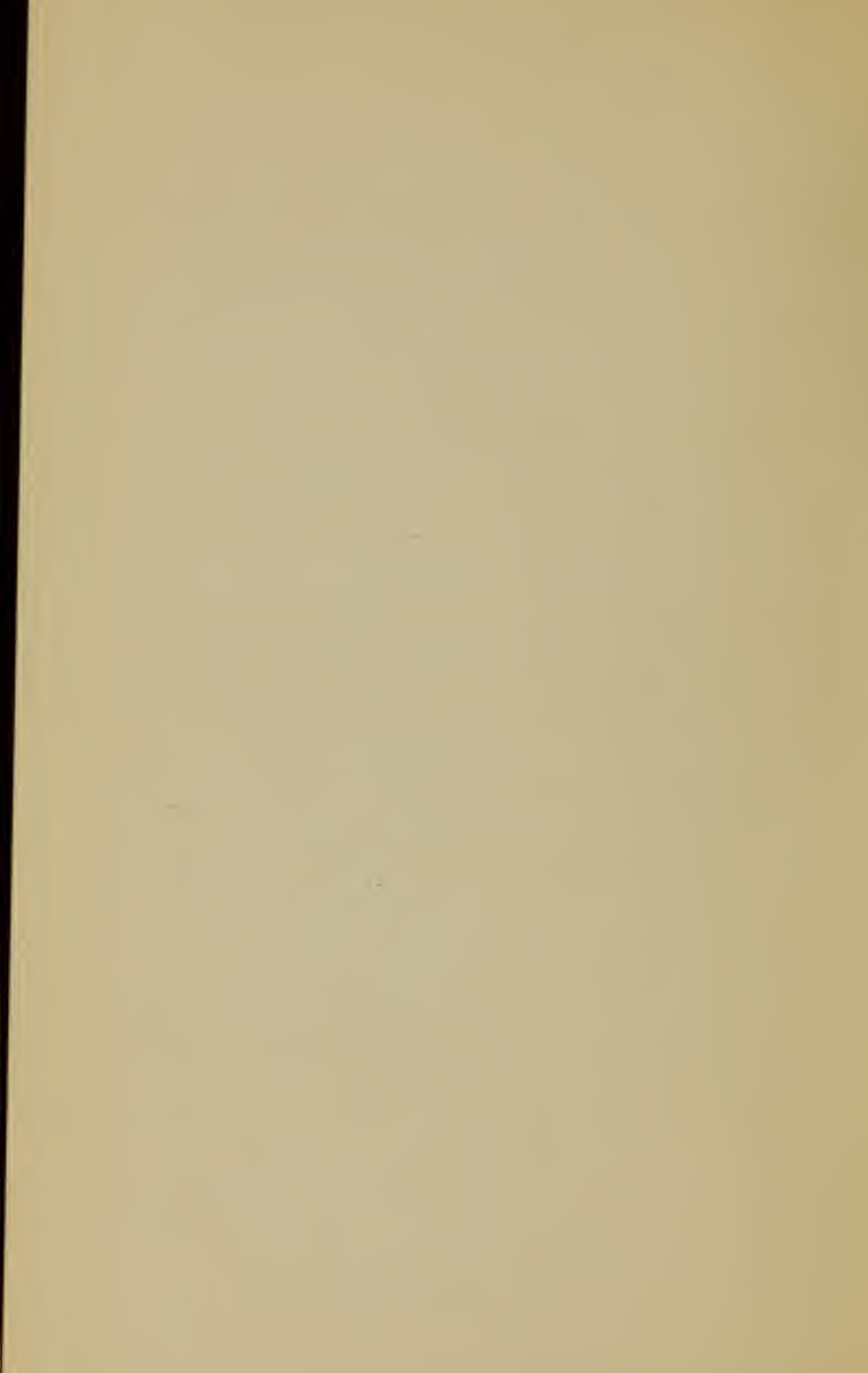
OTTO MEYER, M.D.

At last, here is an understandable book which deals directly with Phlebitis (inflammation of the veins)... Its enlightening information will be welcome to layman, medical student, nurse, interne and everyone interested in looking behind the scenes of medical science—to learn the truth about one of the most devastating basic diseases of mankind, — *Phlebitis*. The author's conception of Phlebitis as the root and cause of most diseases is so revolutionary that it may change the treatment of diseases completely.

“Phlebitis is the root of all diseases” is a statement made in 1829 in his book “Anatomie Pathologique” by Jean Baptiste Cruveilhier, the first pathologist of the University of Paris. “It is the infection (pollution) of the blood that makes Phlebitis so dangerous”, a contention which has been proved by modern pathologic research. Professor A. Dietrich of the University of Tuebingen states in his textbook of pathology: “Phlebitis and thrombophlebitis are the basis of septicemia.” If we translate the strange word septicemia with the good English words “blood poisoning”, we can understand how infected veins can do so much damage to any part of our system.

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A
NEW APPROACH
TO
OLD DISEASES

A Description of the Source
of Many Diseases

BY
OTTO MEYER, M.D.

1942

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TO MY MOTHER,

a victim for over thirty years of focal infection in the veins, who inspired me to devote myself to the study of the fundamentals of medical science, I dedicate this book.

FOREWORD OF THE PUBLISHERS

The need for informing the layman about medical problems has long been recognized by medical authorities. We agree with Professor Lewellys F. Barker, of Johns Hopkins University, who writes in his book *Blood Pressure*, published by D. Appleton and Company, New York: "It is the layman's right, therefore, to have at his disposal such information as will help him to avoid the beginnings of disease; and, equally, it is his duty to inform himself of preventive measures, to the end that he may live out his threescore years and ten in comfort. Not less is the obligation of the physician to put his knowledge before the public in a simple and understandable form. Only thus does he perform his whole duty as a physician."

Therefore, we have asked Dr. Otto Meyer to write a book about the difficult subject of focal infection. Dr. Meyer has discovered the missing link which makes the theory of focal infection complete. He has written more than fifty scientific papers for medical journals on this subject. During the meeting of the Fourth International Congress on Rheumatism he was a member of the presiding committee.

We feel assured that the presentation of his revolutionary discoveries will alleviate much unnecessary pain and suffering among the victims of focal infection.

The Publishers.

INTRODUCTION

*Science is not an accumulation of facts,
but a logical combination of facts.*

— HIS.

My friends have often asked me how I became interested in diseases of the veins. My mother, who was a victim of focal infection in the veins, is responsible for my special interest in these diseases. Her suffering and her intuition inspired me to do research work in this field.

My mother is the daughter of a physician. When she was a child of about eight years she overheard her father say to another physician: "If the patients only knew how little we doctors know about the true nature of disease, they would not come to see us." She remembered this remark all her life. Through painful experience she found out for herself how true those words had been.

After giving birth to her fourth child she de-

veloped pains and cramps in her legs. Physicians told her she had varicose veins which were causing this trouble. One day she hurt her leg and a large ulcer developed at the site of the injury. The ulcer was treated as a "varicose" ulcer, but without any benefit resulting therefrom. She went from one physician to another without getting relief from this painful condition. The best years of her life were spoiled by this trouble. Finally her legs were treated with salves and several months of complete rest in bed. The result was that the ulcer closed. But the pain and cramps in the legs continued and became worse than ever. Immediately after the ulcer had closed she developed rheumatic pains and also severe gastritis (stomach trouble). Mentally she became so depressed that she actually suffered a nervous breakdown. After a short while the ulcer broke open again. The moment this happened she noticed immediate release from her rheumatic pains and from her stomach trouble. Somehow she felt that her blood was poisoned and that the ulcer offered an outlet for the poison. She was correct in her belief and soon was so much better that she refused to have the leg ulcer treated again; but for at least thirty years she went through agony from local pain in the ulcer which remained open through all this time.

When I was a medical student I told several famous medical professors of my mother's experience with her ulcer. The reaction of all these men was the same. Every one of them told me that nearly all "old

women" suffering from varicose ulcers tell their doctors that they feel better when the ulcer is open. All intimated that this opinion was the result of imagination. Such an explanation did not seem satisfactory in my mother's case. At any rate, she insisted on the correctness of her observation.

Consequently, when I was still a very young doctor I became much interested in the treatment of leg ulcers. While I was working in Unna's clinic, I read in a French treatise a report by the famous French dermatologist Fournier about "leg ulcers of phlebitic origin." I had always read about varicose ulcers but never about phlebitic ulcers. Varicose ulcers are caused by varicose (dilated) veins while phlebitic ulcers are caused by inflammation of the veins (phlebitis). This report gave me a clue to my mother's case.

The question was now what to do about phlebitis. In medical schools and textbooks we had learned that there was no cure for phlebitis. The only treatment recommended for this condition was rest and elevation of the legs.

In my mother's case I took a fatalistic attitude until I learned from a patient in New York who had suffered for years from phlebitis that he was cured with a "new" method originated by Dr. Heinrich Fischer in Wiesbaden, Germany. I decided to visit Dr. Fischer and ask him about his treatment. I talked to hundreds of his patients, and all were full of praise for Dr. Fischer's ambulatory treatment. I spent some time with

Dr. Fischer and learned his technique. The old physician, then about seventy years old, was a remarkable man and very modest about his achievements. He took a personal interest in me because he realized the sincerity of my desire to cure phlebitis. When I left him I knew that I would be able to help my mother — perhaps even to cure her.

The actual result in my mother's case was nothing short of a miracle. Her pain stopped instantly, and her general condition improved very much. The ulcer closed, and I treated her legs until the deep veins were no longer sensitive to pressure. Since her phlebitis has been cured she has never suffered from rheumatic pains or stomach trouble. She is now more than eighty years old and feels better than when she was middle-aged.

I became more and more interested in the effect of phlebitis on the general health of the patients. My results with the revolutionary Fischer treatment were generally satisfactory. Many patients told me they had been completely relieved of rheumatism since receiving the treatment. Even rheumatic pains remote from the legs, such as those in the elbow or finger joints, disappeared completely after the removal of the infection in the deep veins of the leg. My conclusion was that their rheumatic pains originated from the infection in the veins of the legs, perhaps by long-range action of bacterial poisons (toxins). These toxins are formed by the germs which cause the infection in the veins.

When rheumatic sufferers heard about these results they consulted me. Their legs appeared to be normal and did not cause any local trouble. But the deep veins of the legs were very sensitive to pressure. I suspected a latent (concealed) infection of the veins and treated them for phlebitis. When their rheumatic pains in the joints remote from the legs disappeared, I concluded that latent phlebitis actually was a point of origin for bacterial poisons.

In some cases I did not obtain satisfactory results with my treatment of the leg veins. I suspected that some "feeder" must nourish the infection in the legs. I examined the jugular veins and found, in refractory cases that did not respond promptly to treatment, that the jugular veins were sensitive to pressure. Healthy veins can stand much pressure without any pain. I looked for literature on chronic inflammation of the jugular veins but could not find any reference to it. I decided to consult a pathologist on this problem and visited Professor Dietrich in Tuebingen who had written a book on diseases of the veins. After he told me that he had proved in autopsies that acute infections of the tonsils spread to the jugular veins, I made the deduction that the spreading mechanism in chronic infections must be the same. Another pathologist, a former pupil of Dietrich, also found in autopsies that acute infections in the jawbones (teeth) also spread by way of the small connecting veins into the jugular veins on both sides of the neck.

After I had found a safe way to remove the concealed infection in the jugular veins, I had no more difficulty in clearing up the infection in the veins of the legs. The "feeder" idea proved to be correct.

My surprise was great when I heard from patients whose jugular veins I had treated that they were relieved of stiff neck, high blood pressure, migraine, sinus trouble, eczema of the face, and other ailments in the region of the head. I concluded that these results were due to a decongestion of the head by removal of the inflammatory swelling within the jugular veins. The swelling of the inner wall of the jugular veins caused by infection had interfered with the drainage of the blood from the head.

Besides the beneficial results that the treatment gave for rheumatic pains, I observed that the general health improved greatly after the removal of the infection in the veins.

After many years of concentrated work on vein diseases I have become convinced that the discovery of hitherto unknown concealed infections in the veins will have far-reaching influence on the future development of medical science.

OTTO MEYER, M.D.

New York, January 1942.
200 West 54th Street.

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CHAPTER I

BLOOD, THE BODY'S GREATEST REPAIR FORCE

*"Find out the cause of this effect,
Or rather say, the cause of this defect,
For this effect defective comes by cause."*

Hamlet

"Natura sanat, medicus curat" was the motto of the old Roman physicians. It means "Nature heals, the physician only treats diseases." Many diseases heal by themselves. In these cases the natural healing power of our body effects the cure. The famous Greek physician, Hippocrates, the father of medicine, called the cure of

diseases by nature “physiatrics” (from the Greek words *physis*, nature, and *iatreia*, healing).

The natural healing power is effective only under favorable conditions. It must therefore be the objective of every physician to produce the proper conditions so that nature can heal diseases. The physician must be the pacemaker of nature’s healing efforts. He should serve nature, not attempt to be its master. His task is to remove everything that inhibits the natural healing power of our body. To support and, if possible, to supplement the natural healing power of the body is the only rational method of treatment, since the body always tends to rid itself of diseases. In stimulating the defense mechanism of the body against disease the physician helps the body to recover its health in the most effective way and without the danger of undesired or harmful after-effects. In all methods of treatment there is one essential principle for physicians: the treatment must not do any harm to the patient.

The success of any treatment depends on correct diagnosis, which is the art of recognizing a disease from its symptoms. The old Roman physicians used to say “Qui bene diagnoscit, bene medebitur” (who recognizes a disease well, can treat it well).

In the treatment of diseases we differentiate between causal treatment and symptomatic treatment. Causal treatment goes to the root of the disease, while symptomatic treatment only alleviates or relieves symp-

toms of the disease without curing it. It is obvious that causal treatment is the better of the two, because it removes the cause of the disease and thereby effects a true cure.

The physician therefore must strive to support the natural healing power of the body in the most effective way and without harming the patient. This can be done only if we are able to recognize the true cause of diseases by a correct interpretation of their symptoms. If we know the cause of a disease, we can often use a causal treatment and cure the patient instead of merely removing his symptoms temporarily.

As most diseases are caused by disease-producing germs, it is highly important to know that germs have a tendency to settle in the walls of the veins. We are justified in calling this affinity between germs and veins "phlebophily". This word is composed of the two Greek words *phlebos*, vein, and *philos*, loving. When the germs form a colony in the inner wall of a vein, they produce an inflammation of the vein (phlebitis). The germs, once they are intrenched in the wall of the vein, manufacture poisons (toxins) which are shed into the blood stream and cause poisoning of the blood. These poisons may cause symptoms of disease in any part or organ of the body. The point where the poisons are produced is usually concealed and sometimes a long distance away from the point where they attack an organ, causing inflammatory processes, pain, and other symptoms of disease.

I discovered the concealed infections in the veins after years of research. On the basis of my experience and observations I have come to the conclusion that these concealed infections in the veins are responsible for many diseases, especially the chronic ones.

The principle of my method of treatment is the purification of the blood from bacterial poisons. It is my contention that the basis for nature's healing power is healthy blood in healthy blood vessels, for blood is the body's greatest repair force. This point has not been stressed sufficiently in modern medicine.

My conception of the true cause of many diseases may sound revolutionary to some physicians. I invite every physician to test the correctness of my statements and to offer constructive criticism of my conception of concealed phlebitis as the cause of many diseases. Every discovery in medicine should be examined critically, but without bias. The highest law in all branches of science is impartial search for truth. The true scientist will test everything and refuse nothing that has been found to be good.

The modern physician wants liberty of thinking and liberty of science. He refuses to submit to coercion that is exerted with the purpose of forcing him to accept only the customary and conventional methods of treatment. Progress in medicine can only be achieved by independent thinking and by the courage to defend new ideas and observations in public.

We can be thankful that we live in different times than Servetus and Semmelweis did. Servetus who discovered the pulmonary circulation was burned to death. Semmelweis was persecuted, because he, the pioneer of antisepsis in obstetrics, dared to save the lives of expectant mothers by the "revolutionary" request that physicians and students wash their hands with soap and water before examining pregnant women.

Dr. Arturo Castiglioni, the author of *A History of Medicine*, writes in his book: "Semmelweis' views on the subject were so fiercely combated by many of the illustrious obstetricians of his time that he was forced to resign from his position at the Vienna Krankenhaus. In 1845 he became Professor of Obstetrics at Budapest, where he published his great work '*Die Aetiologie, der Begriff und die Prophylaxis des Kindbettfiebers*' (Budapest and Vienna, 1861). His courageous championship of asepsis in obstetrics, which ushered in a new era in the history of this discipline, did not prevent him, however, from becoming a victim of the persecutions of his enemies, a martyr to his discovery, dying in his prime in an insane asylum."

In this connection it seems to be appropriate to mention the words of the famous French neurologist Charcot: "In the last analysis, we see only what we are ready to see, what we have been taught to see. We eliminate and ignore everything that is not a part of our prejudices."

CHAPTER II

WHAT IS FOCAL INFECTION?

Causa latet: vis est notissima.

(The cause is hidden but the result is known)

Ovid

Nearly a century and a half ago, in 1801, an American physician made some very far reaching observations. He saw a woman, suffering from rheumatism of the hip joint, cured by the removal of a decayed tooth. He noted that another woman rid herself of dyspepsia by the same procedure. A man, plagued by epilepsy, was healed by the extraction of diseased teeth. The doctor was so impressed by all this that he felt it imperative to urge that physicians examine the

mouth of patients suffering from chronic diseases and remove infected teeth.

Little did Dr. Benjamin Rush dream that he had hit upon the first clue to understanding the true nature of a process which is the original cause of a number of illnesses, among which rheumatism occurs the most frequently. His discovery of the direct relationship between diseased teeth and diseases elsewhere in the body led, in the course of time, to the "Focal Infection Theory" which has proved of tremendous benefit to physicians and patients alike.

To understand the problem of focal infection the reader must have some general knowledge about infections. Originally the word *infection* expressed the idea of contamination with some disease-producing matter. The word was used long before the germ theory of the diseases to which it is now applied was known.

The modern definition of infection is "the state produced by the entrance into and multiplication in the body of pathogenic (disease-producing) micro-organisms." In other words not all germs cause infection. There are many bacteria (germs) on the outside of our bodies causing no trouble, and there are innumerable bacteria in our throat and intestinal canal that do no harm.

A combination of three factors gives rise to an infection: the germs must gain admission; the germs must grow in our tissues; the germs must cause disease.

Infection consequently means that some patho-

genic (disease-producing) germ has invaded and caused disease in the body. The danger of an infection is largely due to the toxins (poisons) which are manufactured by the germs. These toxins are as well able to produce inflammation of a tissue as the germs themselves.

Not all individuals react alike to infections. Some conquer an infection very easily because their body has a good defense mechanism. Others succumb to an infection very easily. The reaction of the individual to infection depends on his vital resistance. Another factor is the virulence of the germs. Some germs are less poisonous than others.

Most of you have doubtless heard of focal infection, but I am sure that only a few of you have a clear conception of the meaning of the term. You may have a vague impression that it has something to do with diseased teeth or tonsils, but, if you are the average patient, you know little or nothing concrete about focal infections. Since intelligent cooperation between the physician and his patient will often speed up the latter's recovery, a clear understanding of medical terms and therapeutic procedures can be most beneficial, since there is not one of us who is not a potential victim of disease.

The modern patient wants to know just why, for example, his doctor wants him to have his teeth extracted or his tonsils removed. After all, no one can blame a rheumatic patient, whose symptoms are not yet

fully developed, when he balks at the extraction of the one tooth which is essential for the support of bridgework that has just cost him a small fortune. But if he once understands that an apparently healthy tooth may be the breeding place of disease germs which are the cause of rheumatism, he will realize how imperative it is to follow medical advice, even though that advice is not to his liking.

Focal infection, often called simply "focus", is as much a disease caused by germs as is any other infection. While it is not a specific infection like typhoid fever or pneumonia, it may be caused by any germ that is able to produce an infectious disease. In most focal infections, however, we find the dangerous streptococci or staphylococci. The focal infection may be located in any part of the body, although there are certain organs where it is most frequently found.

The one characteristic that puts focal infection in a class all by itself is its tendency to cause other diseases in some other part of the body. In fact, this tendency is responsible for the name. "Focus" is a term used chiefly in physics which means a point from which rays of light, heat, or sound, diverge or appear to diverge. Therefore the focus is the central point or the source of light, heat, et cetera. Accordingly, an infection is called FOCAL infection, or FOCUS, when it is the source from which another disease springs.

Most frequently, although not invariably, focal

infection is concealed and silent. The infected tooth or the infected tonsil causes no pain. The infection goes on sluggishly. Since there is no pain at the site of these concealed infections we can understand why it took so long to discover them. These infections seldom provide obvious symptoms, such as pain or swelling, to draw the patient's attention to its existence. You may ask then, "Why bother with it, if it doesn't cause any disease symptoms?" The answer to that question is, of course, that, sooner or later, all focal infections do cause trouble. The symptoms will inevitably appear. But the pains, aches, swellings, and other distressing manifestations, will probably show up in quite another part of the body, remote from the site of the focal infection which caused them. For instance, a patient may be convinced that the swollen, stiff, rheumatic knee which is troubling him has its origin right there, either in the painful joint itself or somewhere close by. Actually, that rheumatic knee probably springs from a focal infection located some distance from the pain as, for instance, in a seemingly perfect tooth. The connection is easy to understand if we but realize the simple fact that germs produce *poisonous* substances (known in medical language as "toxins") which are able to cause diseases anywhere in the body.

Following this theory to its logical conclusion, two questions immediately arise. First, how does the toxin get from the tooth to the knee as in the example we

have chosen? And, second, why does the toxin attack the knee and not any other part of the body?

The first question is comparatively simple to answer. The toxin travels with the bloodstream which is the communication system connecting all parts of the body with one another. The toxins are originally deposited by the germ in surrounding tissue. Since they constitute a substance foreign to the tissue, they are carried away by the bloodstream to the organs of excretion in order to be destroyed and eliminated from the body. But, on their way, they come in contact with many organs which are thus exposed to their destructive action, such as, in our example, the knee.

It is more difficult to answer the second question without becoming technical. First, we must bear in mind that, under normal conditions, healthy tissue is able to resist the attack of toxins and germs. If this were not true, all higher organisms would long ago have been exterminated by the destructive action of the vicious, invisible germs and their toxins. This ability to resist the attack of germs and toxins is called immunity, and every human being has that immunity in a more or less pronounced degree.

One of the numerous factors which determine the extent to which a person is immune to germs is the general condition of the body. An individual who is healthy and well nourished is much better equipped to resist the action of germs than is a weak, sickly person who has not enjoyed a square meal in months. The

same thing is true of the various parts of the body itself. Any organ which is temporarily weakened is wide open to the attack of germs or toxins. Thus if an organ is affected, we must assume it was unable to resist the action of toxins because of some abnormal, local condition which decreased its power of resistance. In our example, the knee might have been weakened by a previous strain or injury, or by lack of proper blood circulation.

Often, however, it is impossible to detect the exact reason why one particular part of the body is affected by toxins circulating in the bloodstream, while others escape harmful effects even though they may have been equally exposed. There are still many points which have not been clarified by medical research. One fact, however, is certain. When toxins are circulating in the bloodstream, any and every organ of the body is exposed to their attack, and at any time may fall prey to their injurious activity.

By now, I am sure, you must want to know why focal infections often do not cause symptoms of their own, and thus remain hidden. In order to understand this curious fact, it is necessary to realize that the aggressiveness of disease germs varies greatly. Just as the resistance of the human body varies with its condition, the deadly power of the germs to inflict diseases is dependent on the same factor. If a weak germ enters strong, healthy tissue, it is destroyed. But if the germ is just strong enough to cause an infection while the

body, too weak to kill the germ, still has enough defensive power to prevent the infection from spreading, a stalemate occurs. The body builds a special defensive tissue, called granulation tissue, with which it surrounds the germs, thus preventing the infection from affecting the rest of the body. When an infection is walled off in this way it creates only a few direct symptoms, if any, and would not harm the body were it not for the fact that it still produces toxins through its confined germs. For, although the germs themselves cannot penetrate the protective wall of granulation tissue, their toxins are swept into the blood and carried all over the body as we have already seen.

If the protective wall of granulation tissue breaks down, or is injured by wrong therapeutic measures (for example, squeezing a boil), the germs themselves are set free to invade the neighboring tissues, or to enter the bloodstream more readily. Then they may cause other infections anywhere in the body.

If focal infections cause so few direct symptoms, or even none at all, how then is it possible to locate them?

In order to track down hidden infections of this kind, it is of prime importance that the physician be aware of the possibility that they may exist. He must never forget to consider them. Although there may be no direct symptoms at the site of a focal infection, there are always enough signs of a general nature which not only show something wrong with the health of the

patient, but also indicate the possible existence of some focal infection. Among such *general symptoms* are abnormal fatigue, sleeplessness, headaches, nervousness, nervous indigestion, and a host of others. Of course, all these symptoms may be caused by other conditions just as frequently as by focal infection. Oftentimes they are due simply to an unreasonable way of living, lack of sleep, too much work, or too much play. Therefore, before looking for a concealed infection, the physician must always first exclude all the obvious possibilities.

The presence of certain specific diseases is another practically positive sign of the existence of a focal infection somewhere in the body. Rheumatism in its different forms is the most frequent condition caused by focal infections, and the one which perhaps causes more human misery than any other disease. As is generally known, it may occur as muscular rheumatism, as rheumatism of the joints or arthritis, and as rheumatism of the nerves or neuritis. Practically all cases of rheumatism are caused by the action of toxins produced in a focus. If the toxin attacks the joints, the result is arthritis. If it affects the nerves, we have neuritis. And if it exerts its action on the muscles, it causes muscular rheumatism. Therefore, if a patient suffers from rheumatism, it is most likely that he carries a focal infection in his body which must be found and eradicated in order to effect a cure.

Once it is evident that there is a focus in the body,

the physician will begin his search by examining those organs which he knows by experience are most frequently the seat of focal infections, such as the teeth, the tonsils, and the veins.

Other foci, mostly secondary foci, that do not come within the scope of this book, are found in the gall bladder, prostate gland, and some other organ of the body.

Every infected tooth may be a focus. A concealed infection can sometimes be found by x-ray examination, although not in all cases. Experience has taught that dead teeth, that is, teeth in which the nerve has died or been removed, are almost always infected, even though the x-ray picture does not reveal any abnormal condition. For this reason every dead tooth must be regarded as a likely seat of a focal infection.

Focal infections located in the tonsils are comparatively easy to uncover. It is important to bear in mind here, too, that the outward appearance of the tonsils does not always give a true picture of their health. Apparently healthy tonsils may be revealed as infected under an expert, genuinely thorough examination.

Experience has shown, however, that both infected teeth and tonsils have many times been removed without benefit to the patient. In some cases of rheumatism the removal of infected tonsils brings immediate results. But in other cases, taking out equally infected tonsils may not relieve the trouble at all.

This puzzle always intrigued me. What could be

the explanation for these apparently contradictory results? The answer proved to be simple. In those cases in which immediate results followed the removal of infected teeth or tonsils, the infection was limited to these organs. In the other cases, I found that the infection had already spread through the small veins of the surrounding tissues to the jugular veins on both sides of the neck, and had there formed an independent focus in the walls of these blood vessels. In other words, the original focal infection in the teeth or the tonsils had caused another independent focal infection in the jugular veins, that is, phlebitis of the jugular veins. Phlebitis is the medical term for inflammation of a vein. This focus in the jugular veins prevented the cure of the rheumatism, for, although the original focus in teeth or tonsils had been removed, there was still a focal spot from which poison could pour into the system. My own experience in treating jugular phlebitis has proved beyond doubt that *jugular phlebitis is the MISSING LINK in the focal infection theory.*

The thought of phlebitis to most physicians conjures up the association "legs". It is true, of course, that the veins of the legs are very often affected in this disease, but the lower extremities are by no means the only parts of the body where it is frequently found. Years ago, Professor Dr. A. Dietrich, Director of the Pathologic Institute of the University of Tuebingen, showed that acute infection of the jugular veins is a common complication of tonsillitis. He demonstrated through

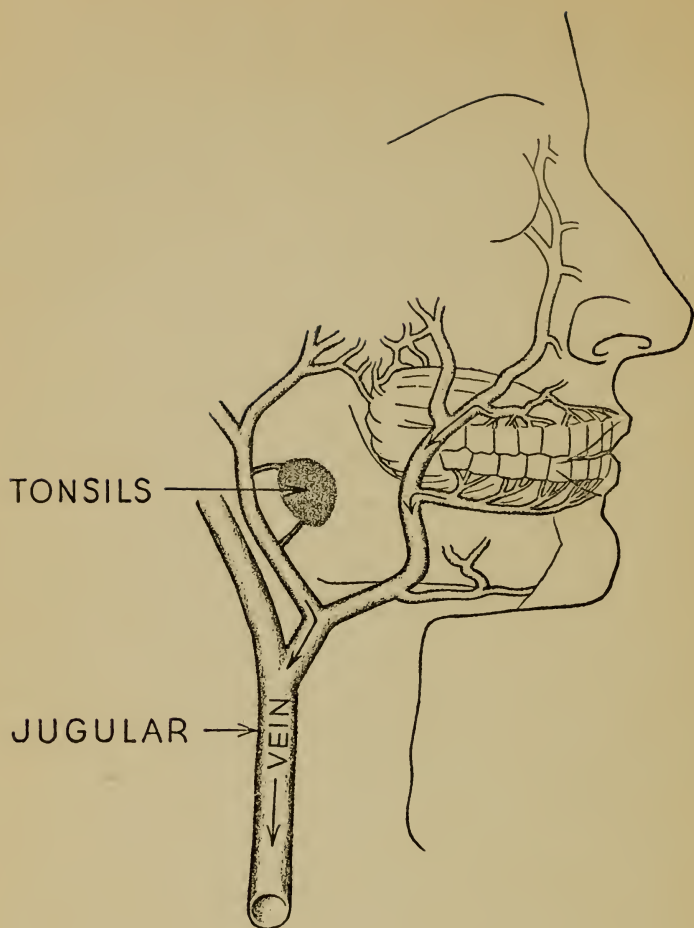


FIGURE 1.

This schematic drawing shows how infections spread from infected teeth and tonsils to the jugular veins by way of small connecting veins.

hundreds of autopsies that the infection almost always spreads from the inflamed tonsils to the jugular veins by way of small connecting veins. Still more recently, another famous Pathologist, Professor Dr. Herbert Siegmund, Director of the Pathological Institute of the University of Kiel, has demonstrated the importance of acute phlebitis in the veins of the neck caused by infection in the teeth and jaw bones. If Dietrich and Siegmund can prove pathologically that, in acute cases, the infection from infected teeth and infected tonsils spreads to the jugular veins, it is logical to assume that chronic infections also spread to these veins and are the cause of chronic jugular phlebitis.

I have found that jugular phlebitis is a very common occurrence, and can be diagnosed in a large number of patients if only the physician takes the pains to look for it. This is especially true of the chronic and latent-chronic jugular phlebitis which I was the first to describe in various medical journals. At the request of the English journal, "Rheumatism", which is devoted to the clinical aspects and treatments of rheumatism, I discussed the connection between phlebitis and rheumatism thoroughly in a scientific paper.

Every physician knows that phlebitis is the cause of septicemia (blood poisoning). So it readily follows that many different diseases can be caused by such focal infections.

Concealed infections of the veins very frequently escape the attention of both the patient and the physi-

cian. Phlebitis of the veins of the leg or of the jugular veins may not produce any local symptoms such as pain or discomfort, but it is much more often present than is generally suspected.

I have stated above that focal infection is often concealed and does not cause any obvious symptoms at the site where it is located. But concealment is not always a characteristic of focal infection. It may be both painful and obvious. In fact, any infection, as for example a boil, can act as a focal infection. In such cases, of course, the discovery of its location offers no difficulties and, since it can be seen, its removal will not meet with any objections from the patient.

Let me repeat that the one characteristic of a focal infection which distinguishes it from any other infection is that its destructive activity is not restricted to the immediate site where it is located. It is able to cause diseases anywhere by the action of the toxins which are carried all over the body by the bloodstream.

We may now define focal infection briefly as follows: *Focal infection is an infection somewhere in the body which pours bacteria or bacterial toxins into the bloodstream and thereby causes disease symptoms elsewhere in the body.*

An infection which does not give rise to another disease, as explained above, is thus not a focus. It may however, become one at any time. Any infection is at least a potential focus and therefore should be eradicated, whether it manifests symptoms or not, as soon as

it is found. Nobody would think of letting a loaded gun lie around the house, although it does not do any harm until somebody presses the trigger, or until it is discharged by being knocked down. Even then it need not injure anybody. But the danger of causing grave injury is so great and so widely recognized, that only fools and very young children would neglect the simple precaution of removing it. A potential focal infection is just as dangerous as a loaded gun, if not more so. It should be removed before it does any damage, rather than after it has caused the body irreparable harm.

Many diseases besides rheumatism are caused by focal infection. As we have seen, every organ is exposed to the action of the toxins, produced in a focus and carried all through the body by the bloodstream. The toxins are especially dangerous to the heart which may be damaged beyond the possibility of repair if the source of toxins is not removed in time. Many cases of nervousness, nervous irritability, nervous indigestion, headaches, and general listlessness are caused by a hidden, unsuspected focal infection. It is easy to understand that the body uses up a great deal of energy when it must counteract the pernicious effects of a chronic focal infection, even though that infection may not have caused another disease such as rheumatism. This explains why general fatigue, lack of energy, loss of appetite, and all the other well-known symptoms associated with a so-called "rundown" condition, are often nothing but a sign that the body is spending a large

amount of its available energy battling against a focus, and preventing its toxins from causing trouble. It amounts to the same thing as if one tried to fight an epidemic of thefts by guarding every house with a special assignment of policemen, instead of catching the thieves and locking them up.

The knowledge of focal infection has enabled physicians to restore the health and happiness of innumerable patients who otherwise would be doomed to premature invalidism. Although it is generally believed to be a modern discovery and is hailed as one of the medical achievements of our age, the credit of first having recognized the connection among apparently unrelated diseases undoubtedly belongs to the American physician, Dr. Benjamin Rush of Philadelphia. The word "focal infection" was coined by one of the greatest American physicians, Frank Billings. He used this phrase for the first time in his paper, "Chronic Focal Infections and Their Etiological Relations to Arthritis and Nephritis" which appeared in 1912 in the Archives of Internal Medicine.

Other American physicians, especially Rosenow, Haden, Duke, McNevins, Adler, Vaughan, Osborne Price, and Martin Fischer have contributed greatly to the theory of focal infection. In fact, European physicians refer to the theory as an American discovery in medicine and have eagerly taken up the research in this field. The famous English physician Hunter, the French physicians Boniguet and Guyot, the German

physicians Miller, Guerich and Paessler deserve much credit for their invaluable contributions.

CONCLUSION

Until now, the theory of focal infection was incomplete. The missing link in the focal infection theory is the concealed infection in the veins. Focal infection is most frequently located in the veins. The poisonous products (toxins) manufactured by the disease-producing germs enter the bloodstream and cause poisoning of the blood. Through the bloodstream the toxins can reach any organ of the body, and may thereby cause disease symptoms in any part of the body. The site of the central infection may be so concealed that it does not show any symptoms. It may be a long distance away from the point where the result of the infection shows up. We may thus speak of a long-range action of toxins.

CHAPTER III

FOCAL INFECTION, THE CAUSE OF MANY DISEASES

Omnium rerum principia parva sunt.

(The beginnings of all things are small.)

Cicero

As we have seen, focal infection produces poisons (toxins) which are carried by the bloodstream through the whole body and therefore may come in contact with every organ. For this reason it is easily understandable that focal infection can cause diseases in every organ of the body.

The danger of a focus of infection is well known and has been emphasized by many authorities in this

field. Professor Martin H. Fischer of the University of Cincinnati writes in his book, *Death and Dentistry*, published by Charles C. Thomas in 1940, that he was asked if focal infection alone was responsible for all heart disease, nephritides (inflammation of the kidneys), the ulcerations of the gastro-intestinal tract not due to immediate injury, nervous diseases, disease of the blood vessels, every acute or chronic appendicitis, gastric ulcer, cholecystitis (inflammation of the gall-bladder), iritis, glaucoma, cystitis, prostatitis, many cases of eczema, and all the dysendocrinisms and diseases of the mind not "inherited". His answer was: "That, Gentlemen, is exactly what we mean."

The best known example of a disease caused by focal infection is rheumatism in its different forms. If the toxins manufactured by a focal infection attack a joint, the effect is arthritis (rheumatism of the joints). If the bacterial poison attacks a nerve, the result is neuritis. If the same bacterial poison causes inflammation of the muscles, the patient suffers from muscular rheumatism.

However, there are numerous other diseases caused by focal infection which are almost as common as rheumatism.

Professor Osborne of Yale University, one of the foremost authorities on focal infection, states in his book, *Mouth Infection*, page 5, that "a focus may be the cause of all kinds and types of diseases, from skin diseases, boils, carbuncles, rheumatism, and neuritis,

to the most serious types of endocarditis, ulcer of the stomach or duodenum, appendicitis, pyelitis, acute infection of a kidney and chronic nephritis. Various endocrine gland disturbances, more especially the thyroid, serious disturbances of the blood, and especially a general septicemia from streptococci may have their origin in the mouth." On page 10, the same author comes to the conclusion that chronic invalidism may be caused by focal infection; that the blood pressure may be raised or lowered by focal infection; that the thyroid gland is frequently enlarged, and may hypersecrete or hyposecrete, in these infections; that serious disturbances of the blood, heart, and joints are frequent from focal infection, that glycosuria can be, and perhaps true diabetes mellitus may be, caused by focal infection; that serious distant infections may occur from focal infection; that serious brain and nerve disturbances, as well as neuritis, may occur from focal infection; that ulcer of the stomach, pyelitis, appendicitis and chronic colitis may be caused by focal infection; and, finally, that pneumonia, especially that which follows influenza, may frequently be caused by pneumococci long carried in the patient's mouth.

The toxins produced by the germs in the infected veins, especially in the jugular veins, frequently attack the heart muscle, causing myocarditis. I have treated a number of patients suffering from this condition with striking results, merely by removing a concealed infection in the jugular veins. Angina pectoris also responds

in many cases favorably to the removal of a concealed jugular phlebitis. About a year ago I treated a physician for jugular phlebitis who had suffered from severe attacks of angina pectoris for years. He told me that after the removal of the jugular phlebitis the attacks of angina pectoris had completely ceased. After his recovery this physician treated a number of his patients who suffered from angina pectoris successfully by removing an existing jugular phlebitis.

Relatively few people are born with a heart defect. Usually heart disease develops as a result of infection. The most common types of heart disease are caused by the invasion of the heart by germs or toxins which damage the heart muscle, the valves, the tissue lining the cavity of the heart, or the bag of tissue which surrounds the heart. Heart weakness or heart failure during or following an infectious disease, such as diphtheria, scarlet fever, pneumonia, and influenza, is caused as a rule by the poisonous effect on the heart and blood vessels of toxins produced by the germs and by the great strain placed on the heart in helping the body to overcome the infection. Occasionally the germs themselves may be carried by the blood to the heart and find lodging there, with consequent damage to the heart tissues. Toxins produced by infection poison the heart. They are often responsible for irregularity of the pulse and palpitation of the heart.

Pruritus ani (intense itching in the anus region) is ascribed to focal infection by Dr. J. F. Montague, New

York specialist on rectal diseases, in his book *The Modern Treatment of Hemorrhoids* (Lippincott, 3rd edition 1938).

Besides the diseases already mentioned, focal infection is a contributive factor in allergic diseases, such as hay fever, eczema, and asthma, in essential hypertension (high blood pressure not caused by kidney disease), and, indirectly, as we shall see later, in many diseases in the region of the head.

The relationship of infection in the veins to erysipelas and erythema nodosum has been described by the author in two medical papers.

In order to understand clearly the mechanism of focal infection it is necessary always to bear in mind that the focus produces a mild form of chronic blood poisoning (toxemia) which affects the whole body. The importance of this fact cannot be over-emphasized. The normal functioning of every organ of the body depends primarily on a constant and sufficient supply of healthy blood which brings to each organ the oxygen and the nourishing materials without which it cannot exist. Therefore, blood that is contaminated with poison (toxin) adversely affects the whole body to a more or less pronounced degree. The fact that the whole body is affected by the blood poisoning due to a focal infection is demonstrated by the general symptoms which are always present in this condition.

The *general symptoms* vary in each case, but we always find some of the following symptoms: lack of

energy, fatigue, frequent headaches without apparent reasons, dizziness, lack of appetite, sleeplessness, nervousness, nervous excitability, irregular pulse, palpitation of the heart, and many other similar symptoms of a general nature. One of the principal symptoms of focal infection is fatigue. All paths are uphill to the tired. A person who gets unduly weak and tired after only moderate exercise is certainly in a subnormal state of health. Apparently all the energy is used to fight the infection in the bloodstream. It is remarkable how patients who were tired for years regain their energy after the removal of the infection in the veins. These symptoms often indicate the presence of a chronic blood poisoning, and therefore cannot be cured by tonics, sedatives, change of climate, rest cures, vitamins, special diets and similar measures. In these cases, it is necessary to find and to remove the focal infection which causes the poisoning of the blood. As most focal infections are located in the veins in the form of phlebitis (inflammation of the veins), it can be truly stated that the health of the body depends on the health of the veins. Healthy veins keep the blood healthy.

Why this fact has so long eluded the labors of medical research is difficult to understand, especially since it had been clearly perceived by the genius of the famous French pathologist, Cruveilhier, who wrote as early as 1829 in his book, *Anatomie Pathologique*, "La phlébite domine toute la pathologie" (phlebitis dominates the whole science of diseases). He stated in

other words that phlebitis is the root of all disease. Cruveilhier affirmed also in the same book: "The infection of the vein itself is not more dangerous than an inflammation in another part of the body. It is the infection (pollution) of the blood that makes phlebitis so dangerous." Cruveilhier's contention has been proved by modern pathologic research. Professor A. Dietrich of the University of Tuebingen states in his textbook of pathology: "Phlebitis and thrombophlebitis are the basis of septicemia." If we translate the strange word septicemia with the good English words "blood poisoning", we can understand how infected veins can do so much damage to our system. Our health depends on healthy blood in healthy blood vessels. Healthy blood is the best disinfectant of the human body. I predict that the future of medicine will be based on the recognition of phlebitis—especially of the latent (concealed) infection in the veins—as the root of nearly all diseases. Some day doctors will say: "You are as healthy as your veins."

CONCLUSION

As focal infection produces toxinemia, which is a poisoning of the blood with toxins, every organ of the human body is apt to be attacked by these bacterial poisons (toxins). The result is a disease in some part of the body which is usually some distance away from the cause (focus).

CHAPTER IV

THE MECHANISM OF FOCAL INFECTION

Focal infection is primarily a toxinemia, in other words a poisoning of the blood with toxins which may cause acute or chronic diseases. In such cases the toxins (poisons) produced in a focus are poured into the bloodstream and carried to an organ which they attack. For example, the toxins may be formed in the jugular vein (focus) and may attack the knee joint. Then the jugular vein infection is the toxin factory that is the *point of production* of the toxins; the knee joint is the *point of attack* of the toxins. The bloodstream is the *conveyor belt* of the toxins between the focal infection (point of production) and the attacked organ (point of attack).

In most cases of focal infection we find few symptoms at the site of the focus. The local damage is so concealed that hardly any local disturbances point out

the focus. The local damage is negligible in comparison with the long-range damage of the toxins produced in the focus. The focal infection itself may look harmless to the layman but its insidious effect is always dangerous to the health of the patient. A completely painless infection of the jugular vein may be the cause of the most painful inflammation of the arm nerve (brachial neuralgia). A concealed infection of the deep veins in the leg that is entirely free from local pain can cause very painful backache. Recently I saw a child who had been suffering from chronic bronchial asthma for years. The culprit in this case was a harmless looking pivoted front tooth. The x-ray picture did not show anything abnormal in the surroundings of this tooth. But the jugular vein was infected. I suggested extraction of this tooth. The mother refused the extraction for sake of appearance. Finally the family physician persuaded the mother to have the questionable tooth removed. After extraction of the tooth and removal of the infection in the jugular vein the asthmatic attacks stopped completely.

All organs of the body are exposed to the action of the toxins, but only those whose vital resistance is lowered are apt to be attacked. The lack of vital resistance may be due to former diseases or injuries, or it may be inherited.

The influence of heredity seems to be important. Just as all human beings have a different vital resistance, so one individual organ of the body may be more

predisposed to diseases than another. In some families, the heart and blood vessels are susceptible; in others, the kidneys, the liver, and so forth. Medical science knows that the tendency to some diseases is inherited. There are families in which the tendency to gout, diabetes, obesity, asthma, arteriosclerosis (hardening of the arteries), stomach ulcers, high or low blood pressure, hemophilia, goiter, glaucoma, cataract, and other conditions, is inherited. The diseases themselves are not inherited, but the tendency to them is inherited.

The best proof of inherited disposition to diseases is offered by twins. We find often the occurrence of identical disease in identical twins. Kretschmer described as an example of the inherited constitutional basis for disease the case of twins who, within seven months of each other, both developed kidney tuberculosis, especially in the right kidney. The lungs and other sites equally open to the attack of the invading tubercle germs were not affected.

Especially susceptible to the attack of bacterial poison are injured or scar tissues. This explains why the toxins especially attack joints that have suffered in their local resistance through injuries and accidents. Also, scar tissues are attacked often by the toxins, and this fact explains the pain in adhesions.

Another important factor in toxinemia is elective affinity, which is a force by which a substance chooses or elects to unite with one substance rather than with another. Organotropy is the affinity of substances for

certain organs or tissues of the body. The pneumococcus germ, for example, is attracted to the lung tissue; the meningococcus to the meninges (the lining of the brain); the gonococcus germ to the genito-urinary organs and the joints. A similar affinity of toxins to certain tissue seems to exist, and explains why one organ rather than another is especially attacked by them. The fact that we find no germs within the joints in rheumatic arthritis seems to indicate that the damage to the membrane of the joints is done by toxins. Weintraud speaks, in such a case, of an arthrotropy of the bacterial toxins. The word arthrotropy is composed of the Greek words *arthron* (joint) and *tropos* (turning toward). In arthrotropy, the bacterial poisons have a tendency to settle in the joints. The toxins cause an inflammation of the joints. If the toxins attack the nerve tissue and cause inflammation of a nerve (neuritis), we are justified in speaking of a neurotropy. In 1897 the famous Austrian surgeon, Chvostek, asserted that in rheumatic arthritis not the germs as such settle in the joints, but that the inflammation of the joints is due to the action of the bacterial toxins.

Some authors are of the opinion that toxins produced by bacteria in a focus, when absorbed, cause systemic reactions of an allergic nature. This bacterial allergy is a specific hypersensitiveness to bacterial toxins.

I have been asked by several patients whether focal infection can be determined in a blood test. Since focal

infection affects our general health by dissemination of bacterial toxins in our bloodstream, this question seems to be justified. But the exact chemical nature of bacterial toxins is not known. For this reason it is not possible to detect the toxins in a laboratory test of the blood.

An elective localizing quality of the germs of the primary focus has been claimed by the famous Dr. Rosenow. Rosenow states that "an 'elective localization' has been used to designate the tendency of certain bacteria, especially streptococci, from various localized areas of infection or more normal mucous membranes (such as nasopharynx) or systemic lesions, to localize and produce lesions in animals corresponding to those in patients or animals from whom the microorganisms were isolated."

If any part of the body is especially low in its resistance the physician speaks of a "locus minoris resistantiae" (a spot of lessened resistance). These parts of the body are most liable to take on a disease condition in consequence of exposure to any disease-causing influence. The most important factor in lowering the resistance of the tissue in regard to germs or toxins is venous or passive congestion which means an accumulation of venous blood in a certain part of the body. The congestion in the veins is due to obstruction to the escape of blood from that part. The result is an excess of blood in the affected part. The outflow of blood from the congested area is decreased in most cases by swell-

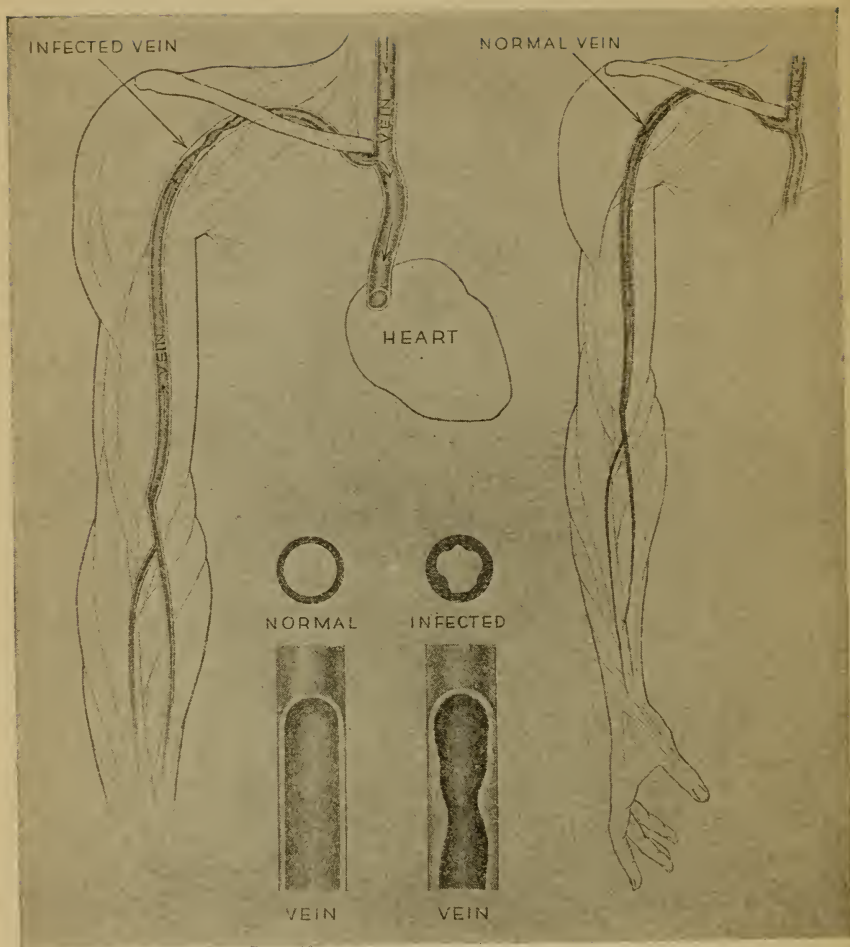


FIGURE 2.

ing in the inner wall of a vein due to an inflammation. The diameter of the vein canal becomes too small to allow a free drainage of the impure blood that is supposed to go to the heart and from there to the lungs to be purified. As an example we take a congestion of the arm (see Figure 2). A congestion in the arm area may be responsible for an inflammation of the arm nerve. The toxins produced in the inflamed jugular veins attack the nerve because the local resistance in the congested area of the arm is low. An area of congested venous blood can be compared with a cesspool.

The most important factor in all infections is the vital resistance of the patient. This resistance is inherited with a good constitution. Oliver Wendell Holmes said that if we would be healthy we must choose our grandparents wisely. Our own inheritance, however, is beyond our control. It is understandable that a person with a good inherited constitution has a better resistance than a person in whose family there is a tendency to tuberculosis, diabetes, or other systemic diseases. The development of a disease is related to the health of the body as a whole, much as seed is related to the soil in which it grows.

Vital resistance is maintained, and perhaps even increased, by proper, balanced diet, sufficient physical exercise, enough outdoor life, and sufficient relaxation—especially enough sleep. On the other hand, the resistance of the body may be decreased by physical or mental overwork; by exhaustion (the state of being

worn out); by exposure to dampness or cold; by "catarrhal" infections, such as colds or grippe; by improper diet, vitamin deficiency, alcoholism, dissipation, poor housing conditions, improper function of the digestive organs; and finally by grief and mental "worries".

There is a definite relationship between mind and body which is shown by the influence that mental processes can exert on bodily functions. For example, embarrassment may cause dilatation of the small blood vessels on the face, an effect which is commonly called blushing. Fear may cause disturbance of the heart function.

Fear, grief and worry create lack of mental equilibrium, which disturbs the function of the body and thereby decreases the efficiency of the bodily defense mechanism against diseases of any kind. On the other hand, patients whose bodily functions are not disturbed by "psychic saboteurs" have a much better chance to overcome diseases. In fact, I have observed that deeply religious people, whose minds are at peace, recover more quickly than the average patient whose mind is constantly disturbed by worries about non-essentials.

Emotional conflicts, unhappiness in the family, financial worry, the loss of close relatives, and similar emotional factors, prepare the soil for the seed of the disease which usually originates from a focus of infection.

CONCLUSION

Every focus is a poison factory. The poison which is manufactured in the focus is distributed by the blood over the whole body and attacks those organs that cannot put up sufficient resistance. The lack of resistance may be inherited, or it may be caused by former diseases or accidents. Although the focus is often situated far away from the organ that is attacked by the poison, both are one disease, the focus being the *cause* and the pain in the affected organ the *symptom*. To cure a disease that is caused by focal infection, it is necessary to remove the poison factory which causes the symptoms. The focus which manufactures the poison often escapes medical treatment, because it is usually well hidden in the wall of an inflamed deep vein. It may exist for a long time before producing enough poison to attack an organ at a distant part of the body. But the patient mistakenly dates the onset of his disease from the moment when the attacked organ reacts with pain, swelling, or other signs of an abnormal condition. Hippocrates did not know focal infection, but he described its course when he said: "Diseases usually develop slowly, but their outbreak is often sudden."

CHAPTER V

PHLEBITIS

The whole theory of focal infection was incomplete until I could show that the infection in the veins plays the deciding role in focal infection. Before we discuss the inflammation of the veins, for which the medical term is phlebitis, I should like to have the reader become acquainted with some important facts about the structure and function of the veins.

Veins are blood vessels which carry the blood from the various parts of the body to the heart. They are tubular structures, the walls of which are composed of three coats: an inner, a middle, and an outer coat.

The veins of the body are arranged in two systems. One is superficial and is found in the skin. The other is situated in the deep structures, and serves the muscles, bones, and organs in the cavities of the body.

Therefore, we distinguish between superficial veins, or veins of the skin, and deep veins. The two systems are connected with each other by numerous small veins. When the deep veins become partially obstructed by swelling of the coats, especially the inner one, as in phlebitis, the blood is forced to make a "detour" and to flow through the connecting veins to the superficial veins in the skin, which now have to carry an abnormal load, and therefore become enlarged. In this emergency, the enlarged veins of the skin, taking the place of the deep veins to a certain extent at least, compensate for the loss of carrying capacity of the deep venous system. For this reason, these enlarged veins of the skin are called "compensatory" veins.

The degree to which the venous system of the skin can take over the task of the deep veins depends upon the amount of connecting blood vessels and on the relative size and number of superficial veins, for these conditions vary in different parts of the body. If the veins of the skin are comparatively small and have only few connections with the deep veins, as is the case in the region of the head, their compensatory value is negligible.

DEFINITION OF PHLEBITIS

Phlebitis is an inflammation of a vein. The condition is marked by swelling of the coats of the vein, and often by the formation of a blood clot which is attached

to the inner coat. Such a blood clot remaining at the site of its formation is called a "thrombus". Therefore, phlebitis with thrombus formation is termed thrombophlebitis, which is nothing but another stage of phlebitis.

THROMBUS - EMBOLUS

When a thrombus becomes detached from the wall of the vein, it is then called an embolus. It is carried by the bloodstream to the heart and from there into the lungs, blocking up the blood vessels of this organ. This condition, known as pulmonary embolism, is one of the most dangerous complications of phlebitis and occurs not infrequently following childbirth and abdominal operations. An embolus large enough to cut off completely the inflow of blood into the lungs causes sudden death. Smaller emboli may give rise to abscesses, gangrenes, and other serious diseases of the lungs.

CAUSE

Phlebitis is nearly always caused by germs. There are cases in which phlebitis is brought about by non-bacterial agents, for example, by injuries and accidents, lacerations, fractures, and sprained ankles. Another not infrequent cause of phlebitis is chilblains. But in all

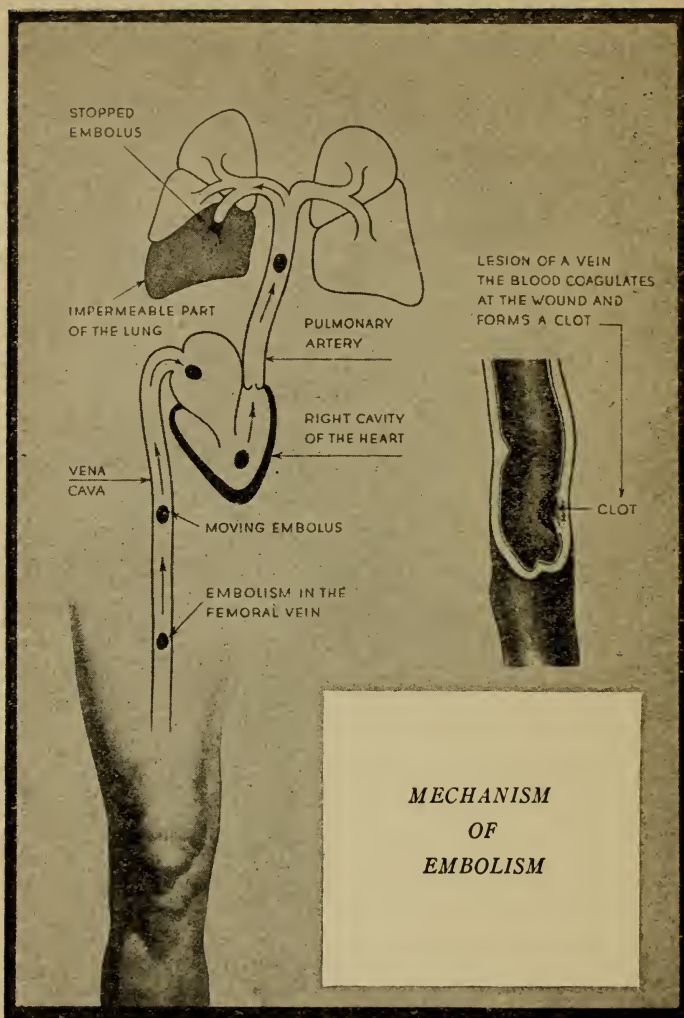


FIGURE 3.

The clot or embolus, caught by the blood stream, is carried to the heart. It can stop at the heart and stop it from beating, or be forced into the pulmonary artery, where it is stopped in a blood vessel of lesser calibre, resulting in immediate death from asphyxia.

cases of phlebitis, germs sooner or later infect the inflamed veins.

There is no specific germ for phlebitis. Any germ which is able to produce a disease in the human body may also cause phlebitis. Professor Audier, the great French phlebologist, speaks of "phlebophilie" of the germs. This expression explains the tendency of germs to settle in the veins. (Phlebophilie comes from the Greek *phlebos*, vein, and *philos*, loving, having fondness). Therefore, phlebitis is frequently a complication or sequel of acute infectious diseases such as pneumonia, pleurisy, scarlet fever, measles, tonsillitis, erysipelas, typhoid fever, puerperal fever, or even common colds, and infections following operations or accidents. Oral infections, especially in tonsils and teeth, often cause phlebitis, especially jugular phlebitis. Streptococci infections, especially a septic sore throat often affects the jugular vein.

Focal infection of the veins is often caused by grippe and may explain why we hear from many patients, "Since I have had the grippe I do not feel well anymore."

The germs are carried to the veins from the seat of the infectious disease by the blood. When we consider these infectious diseases as the cause of phlebitis, we now understand that, for example in the case of typhoid fever, it is the typhoid germ which produces phlebitis, because this germ is carried to the veins by the blood from the original seat of the typhoid fever

in the intestines. Such an inflammation, transferred in this manner from one inflamed part of the body to another, is called metastatic inflammation. To this latter type of inflammation belong also, to name only a few, the inflammation of the ear during the course of measles, and the kidney diseases following scarlet fever.

While these complications are accompanied by symptoms which are easily recognized, phlebitis remains mostly concealed, not even causing pain, nature's danger signal which directs the attention of the patient and physician to the affected part of the body. Not only does phlebitis remain hidden, it seldom heals by itself. If not recognized and treated correctly, it often stays with the patient permanently, and, by poisoning his blood, reduces him to a semi-invalid, deprived of the full enjoyment of life. But this is not all; as we have already seen, other secondary diseases may be caused by it, as, for example, rheumatism.

LOCATION

Phlebitis is usually located in the jugular veins through which most infections enter the bloodstream, or in the veins of the legs. It is rarely found elsewhere in the body. What is the reason for the curious fact, that the germs causing phlebitis nearly always attack the

jugular veins or the veins in the legs, but rarely those in other parts of the body?

The veins in the legs are infected by germs that have entered the bloodstream, either through the jugular veins, or through some other infected part of the body. These veins succumb to infection easily, because the blood circulation in the legs is comparatively sluggish, even under normal conditions. Therefore, the slightest additional strain gives rise to more or less pronounced congestion. Congestion is the medical term for an abnormal accumulation of blood in a region of the body. Thus it can be easily understood why the veins in the legs are unable to offer enough resistance to the germs in the blood, and become inflamed. The local weakness of the circulation causes congestion, and congestion decreases the defensive powers of the veins of the legs against the germs in the blood.

The jugular veins are directly infected by germs that cause an infection in the mouth. The most frequent sources of infection are diseased or dead teeth and tonsils. The infection spreads in these cases from the affected parts to the neighboring tissues of the neck, where the jugular veins are situated, and causes a jugular phlebitis. Or, the germs may be carried directly from infected teeth or tonsils to the jugular veins by way of the numerous small veins that connect these organs. The jugular veins, therefore, are affected so frequently because they are directly and constantly exposed to the

attack of highly active germs from infections in the oral cavity. Grippe infections especially find their way into our bloodstream through the jugular veins.

FORMS OF PHLEBITIS

In phlebitis, as in a large number of other diseases, it is customary to distinguish between acute and chronic forms. These adjectives refer to the duration of the disease and to the severity of the symptoms. Acute means "having a short and relatively severe course with well pronounced symptoms usually accompanied by high fever". Chronic means "having a long-continued and comparatively mild course with less characteristic symptoms and low fever or more often none at all".

Acute diseases as a rule have a very definitely marked onset; the patient knows that he is sick before he calls the doctor. Chronic diseases, on the other hand, often do not advertise their presence for a long time, and are frequently first discovered by a physician during an examination undertaken for other purposes. Both forms of phlebitis are simply different manifestations of the same disorder. This is clearly indicated by the fact that we frequently see the acute form of a disease become chronic and sometimes the chronic form become acute again.

In the case of phlebitis I have found that there

exists still another variation, namely, *LATENT* phlebitis. Latent means CONCEALED, and this word describes exactly the characteristic feature of this form of phlebitis; it is present, but it does not show; it is not obvious like the typical acute or chronic form of phlebitis. Either acute or chronic phlebitis may be latent. LATENT or CONCEALED phlebitis is the most dangerous form, because it undermines the health by causing more or less grave secondary diseases without its existence being suspected by the patient or often by the physician.

Latent phlebitis is the stepchild of modern medicine and has been completely neglected by medical research.

As latent-chronic phlebitis plays such a deciding role in focal infection we are going to describe this condition in detail.

CHRONIC-LATENT PHLEBITIS

The latent form of inflammation of the veins shows no definite local symptoms. The word "latent" applies to that which is present without showing itself. It is concealed, is silent, not visible or apparent. The lack of local symptoms explains why the concealed form of phlebitis escaped detection by physicians for such a long time. Only through many years of concentration

on diseases of the veins and thorough research was it possible to reveal this most important site of infection in the circulatory system. This discovery is of the utmost significance for the treatment of a host of diseases.

The following description of latent phlebitis is enlarged on in my book *Phlebitis*, published in 1940 by the Savoy Book Publishers, New York City.

This concealed form of phlebitis is more frequent than any other form of phlebitis. In fact it is one of the most common ailments. It is nearly always located in the jugular veins and in the deep veins of the leg.

The hidden infection of the jugular vein rarely shows any local symptoms such as pain or swelling. Only a very few patients told me that they had occasionally observed a slight pain on the side of the neck.

The hidden infection of the veins in the legs also shows hardly any symptoms. There is no noticeable congestion in the legs themselves; all the symptoms are due solely to the action of the toxins on the rest of the body. The legs appear to be normal. The victim of this disease is completely unaware of the fact that the veins of his legs are inflamed because, as already stated, there are no direct symptoms which point to the seat of the disease. "I never had any trouble with my legs," is the characteristic and sometimes indignant answer of these patients to the suggestion that the legs should be examined. Unluckily, the patient is right; he never had any trouble with his legs, otherwise he might have

saved himself much pain and discomfort by an early treatment of this seat of chronic infection.

Most of the patients suffering from latent-chronic phlebitis seek medical advice for a rheumatic condition. *For this concealed form of phlebitis is the most frequent cause of every type of rheumatism.* On the basis of this important fact we can say that chronic rheumatism, be it of the joints, the nerves, or the muscles, is nearly always a symptom of a latent-chronic phlebitis.

Patients suffering from latent-chronic phlebitis are always feeling tired, even in the morning just after arising from bed. They often have a sallow, pale complexion, which is due to an anemia caused by the destructive action of the toxins on the red blood corpuscles. Their features show often a tired, listless expression. In many patients, heavy circles around the eyes show lack of sleep. The patients are acutely aware of their pronounced lack of energy, without being able to shake off the tired, worn-out feeling which changes every little effort into a formidable task. They are quickly exhausted, even by so slight an exertion as a short walk or going up a flight of stairs. Standing causes more discomfort than walking. Many patients complain about cramps in the legs.

Sometimes these patients suffer from a splitting headache and attacks of dizziness. Other symptoms frequently due to latent-chronic phlebitis are: blurring of the eyes, fatigue, neuralgia, itching, certain types of

eczema and shingles. Gradually, sometimes a complete nervous exhaustion develops. Many cases of neurasthenia can be attributed to the poison in the bloodstream (blood poisoning) caused by latent-chronic phlebitis.

The first steps in the morning are often painful. But after a little walking, the pain disappears. The same happens when patients have been sitting for some time; it is hard for them to get up. Patients complain often of cold feet. Sometimes they experience numbness in the toes or fingers. Before and during menstruation women generally suffer added discomfort.

Latent-chronic phlebitis and chronic phlebitis affect the whole body, because toxins from these infected veins are poured into the blood and "poison" it. We always have therefore in these cases a septicemia or poisoning of the blood. Professor Dietrich, director of the Pathological Institute of the University of Tuebingen writes in his book *General Pathology*: Phlebitis and thrombophlebitis are the basis of septicemia (poisoning of the blood).

These patients as a rule have tried every conventional method of treatment in their vain search for relief. Their tonsils have been removed, their teeth extracted, and they have been subjected to rest cures and diets. But all these measures have been, of course, entirely useless for none of them has struck at the root of the evil which is the latent-chronic phlebitis in the legs. "They never had any trouble with their legs."

All the symptoms of latent-chronic phlebitis can also be present in the ordinary chronic form of phlebitis and in jugular phlebitis.

Latent-chronic phlebitis may develop from either of the other forms of phlebitis, especially when they have been treated by the ordinary method of putting the patient to bed until the more violent symptoms subside. This method has a tendency to convert acute and chronic phlebitis into the latent-chronic form. Usually, however, latent-chronic phlebitis is the sequel of another infectious disease as described in the chapter on causes of phlebitis. The course of the concealed form of chronic phlebitis is exceedingly slow, and it may take years to develop all the above-mentioned symptoms. But nearly every patient afflicted with latent-chronic phlebitis will sooner or later become a victim of rheumatism, or of a complete nervous exhaustion unless this hidden source of infection is removed from his body.

Latent phlebitis is often the cause of gangrene (dying of tissue) of the toes or feet. This condition has generally been thought to be due to diseases of the arteries. As no effective treatment was known for a condition of this kind the leg was amputated in most cases in order to prevent the spreading of the gangrene. However, in a large number of patients suffering from gangrene the veins are involved. And frequently the latent phlebitis is the main factor in causing the gangrene. I have proved in many cases that the gangrene

can be checked by removing the latent phlebitis of the veins of the leg.

Amputations could often be avoided if the latent phlebitis that causes many cases of gangrene were diagnosed and treated in the early stages.

I agree with Sir Astley Cooper who once said: "He is a good surgeon who can amputate a limb but he is a better surgeon who can save a limb."

I happened to be the first one to describe latent phlebitis as the cause of gangrene of the foot.

My conception of latent phlebitis as cause of gangrene was confirmed in medical literature by Gutzeit. Fontaine, Israel and Pereira of the Surgical Clinic of the University of Paris came to the same conclusion by animal experiments. Lately, Audier, the famous French expert on phlebitis, in a medical paper (*Les gangrènes des membres d'origine veineuse*, *La Presse Medicale* No. 76, 9/21/38) confirmed my conviction, that many cases of gangrene of the foot are caused by phlebitis.

"GROWING-PAINS"

There is still another sign which might almost be called a symptom of latent phlebitis. I am referring to the so-called "growing-pains" in the legs. These pains are not very severe, and occur at irregular inter-

vals. Quite generally they are not regarded as a disease, but rather as a normally-to-be-expected inconvenience of the growing age, like teething for example. This is unfortunate, for I have discovered that these "growing-pains" are mostly caused by a latent phlebitis. Children suffering from "growing-pains" nearly always feel tired, have no "pep", and are bad performers in school athletics. They have a poor appetite. Their faces are often pale, due to secondary anemia, which is caused by the infection in the veins.

Every child who suffers from "growing-pains", or complains frequently of indefinite pains and aches without any apparent reason, should be examined by an experienced physician. Nearly always latent phlebitis is discovered in such cases. The early treatment of this disease will not only restore the former healthy vitality of a child but protect it against acute rheumatic fever and heart disease. Only recently a medical survey showed that many children with "growing-pains" were suffering from heart disease (carditis).

In children it is of utmost importance to pay attention also to the jugular veins which are often infected from tonsillitis and may act as an independent seat of infection (focus). When a child runs a temperature (slight fever) that cannot be explained, the veins should be tested for phlebitis.

JUGULAR PHLEBITIS

Jugular phlebitis is usually caused by infection of the oral cavity, notably by infected teeth and tonsils, as previously stated. The eminent pathologist, Professor Albert Dietrich, director of the Pathologic Institute of the University of Tuebingen, first described the effect of infected tonsils on the surrounding tissues. In acute tonsillogenic septicemia (blood poisoning caused by infected tonsils) he has found, in almost every case, a secondary acute infection of the jugular veins caused by the infectious process in the tonsils. He emphasized the fact that the secondary jugular phlebitis is often the more serious of the two conditions, and frequently persists after the tonsillitis has cleared up. Another famous pathologist, Professor Herbert Siegmund, director of the Pathologic Institute of the University of Kiel, proved in autopsies that infections of the teeth spread to the jugular veins through the small veins which connect the teeth with the jugular veins. It seems impossible, but is nevertheless a fact, that the acute phlebitis in these cases is almost constantly disregarded by physicians.

On the basis of this established fact, namely, that acute jugular phlebitis is a frequent complication of acute infections of the tonsils or teeth, I examined the jugular veins in every patient who came under my observation. I found that almost every patient who had

infected tonsils, or infected dead teeth, also had a **CHRONIC CONCEALED** jugular phlebitis.

Removal of the infection in the mouth (teeth or tonsils) effected a cure of the jugular phlebitis only in a small number of patients. This shows that the jugular phlebitis, although caused by an infection in the oral cavity, soon becomes independent, and must be treated separately in order to be cleared up. Without proper treatment jugular phlebitis seldom seems to heal.

EFFECT OF JUGULAR PHLEBITIS ON THE BODY

Jugular phlebitis affects the tissues of the body in two distinct ways:

First, jugular phlebitis is a focus manufacturing toxins which are poured into the bloodstream and carried through the body where they induce symptoms of septicemia (blood poisoning), or cause specific diseases, notably rheumatism, as explained in the second chapter. Even children are not immune, although they are not as frequently affected during the first two decades of life as in later years. "Growing-pains", as we have said, are often nothing else but a disguised rheumatism, and are frequently caused by concealed phlebitis in the veins of the legs or in the jugular veins.

Second, jugular phlebitis offers a mechanical ob-

struction which prevents the free flow of venous blood from the head to the heart, because the swelling of the coats of the inflamed jugular veins narrows their inner circumference, thereby making it impossible for them to carry a normal amount of blood. As the jugular veins normally carry most of the venous blood from the region of the head to the heart, the result is a congestion of the head.

The region of the head is, therefore, doubly menaced by jugular phlebitis, because its tissues and organs are exposed to the damaging action of a congestion and to the injurious activity of toxins at the same time.

Phlebitis of the jugular veins very often affects the neighboring organs, especially the larynx and the thyroid gland. The venous (impure) blood of both organs drains into the jugular veins. If the small veins which carry the blood from these organs to the jugular veins cannot freely discharge the blood into the inflamed swollen jugular veins, a congestion of the larynx and the thyroid gland results.

The larynx contains the vocal cords, and its function is dependent on a normal circulation. If the larynx is congested, a more or less pronounced degree of hoarseness develops. I have treated several professional singers suffering from this condition whose voices immediately improved after removal of the infection in the jugular veins.

With the same treatment I have obtained good results in chronic bronchitis.

DIAGNOSIS OF PHLEBITIS

To diagnose a disease means to recognize its true nature and to give it its proper name. This we can accomplish by observing its symptoms. Symptoms of a disease are abnormal changes in the body or its functions. They form the clues which lead to the seat of the disease and reveal its nature. There are symptoms which can be recognized only by the patient himself, such as pain, itching, etc. These symptoms are usually of a general nature and may be caused by different diseases.

Headache, for example, can be caused by a growth in the brain, by nervous exhaustion or, as we have seen, by latent-chronic phlebitis. But there are also symptoms which can be recognized by the experienced physician only, and these often indicate positively the existence of a definite disease. These symptoms can frequently be detected only by special methods of examination and are often found only on certain points of the body. For instance, in appendicitis there is a certain point in the right lower part of the abdomen where the physician can find positive proof of the existence of this disease. This point was discovered by McBurney, and is known as "McBurney's point".

Both kinds of symptoms are necessary for the diagnosis of a disease. The complaints of the patient and his reaction to measures of examination point the road which the physician follows in order to locate the

definite symptoms which prove the existence of a disease.

The diagnosis of acute and chronic phlebitis, in its typical manifest forms, is comparatively simple and offers no difficulties. There are so many symptoms in these conditions which indicate clearly the existence of an inflammation of the veins that no doubt can exist with regard to the nature of these diseases. Nevertheless, phlebitic leg ulcers are frequently mistaken for varicose ulcers, and compensatory veins for varicose veins.

Latent-acute and latent-chronic phlebitis on the other hand cause no symptoms which direct the attention to their existence, and, until recently, these conditions could not be diagnosed with certainty. The acute-latent form was entirely unknown until the author showed that it was the cause of acute rheumatic fever and subsequently of chronic arthritis.

The symptoms described in the preceding chapters are always found in latent phlebitis; but, as may be readily seen, they are also present in other conditions. It was therefore necessary to find a method of examination which undeniably indicated the existence of latent phlebitis in the deep veins of the leg.

The solution was found by the author in one of the four characteristic symptoms of every inflammation, namely, "pain". Any pressure exerted upon inflamed tissue causes pain. Therefore, the inflamed deep veins, if subjected to pressure, must be sensitive. On the

basis of this consideration, I have discovered several specific points in the leg where it is possible to exert pressure on the veins. If this pressure causes pain, the deep veins are inflamed. Pressure on healthy veins causes no pain. With the help of the *pressure points*,* the experienced physician can discover a latent phlebitis in every case. Furthermore, their use prevents the common confusion between compensatory and varicose veins, and between phlebitic and varicose leg ulcers. The pressure points also enable us to determine whether the patient is entirely cured. As long as the deep veins are sensitive to pressure, the inflammation is still present, even if the patient does not feel any pain at the site of the infection.

The same principle is used to diagnose jugular phlebitis. If the jugular veins are inflamed, they are sensitive when subjected to pressure.

The general symptoms are valuable because they direct the attention of the physician to the possibility of the existence of a latent phlebitis. But only the pressure points furnish the means of locating the one symptom which absolutely proves the presence of phlebitis. The Journal of the American Medical Association published on page 1566, April 27, 1935, an abstract of a paper by Dr. C. L. Schmidt on the diagnosis of latent

* These pressure points, named after the author (Meyer's Pressure Points) have been confirmed by many authors in medical journals: C. L. Schmidt, Bottenberg, Koehler, Friedlander, Henschen, Becker, and others.

phlebitis. I quote from the abstract: ...“the author found that the determination of the pressure points described by Meyer is a valuable aid in the diagnosis.”

In some cases of latent phlebitis an infiltration of the inflamed vein points to the diagnosis of phlebitis. Infiltration is the accumulation in a tissue of substances not normal to it.

CONCLUSION

The hitherto missing link in the focal infection theory is latent phlebitis, which causes toxinemia (poisoning of the blood with toxins). The primary focus (e.g. tonsils and teeth) infects the veins of the neck and the legs, thereby establishing a secondary or a tertiary focus which usually becomes independent of the mother focus (teeth and tonsils). The concealed toxin factory in the inflamed veins produces bacterial poison which may attack any organ in the human body, and thereby cause disease symptoms in other parts of the body.

CHAPTER VI

RHEUMATISM

Rheumatism is a disease of the joints, or the nerves, or the muscles. It is sometimes attended with fever, and causes aches and pains of varying nature and intensity in the affected organs. The course may be acute or chronic. In either case the disease has a tendency to spread. Under certain conditions it affects the heart, producing valvular and muscular lesions which do considerable damage. If left untreated, rheumatism often disables the patient permanently.

Rheumatism is caused by the action of bacterial poisons which are carried by the bloodstream to all joints, nerves, or muscles, as the case may be. These "bacterial poisons," also called "toxins," which in my opinion cause all "rheumatic" diseases, are produced by one or several circumscribed colonies of germs or

bacteria* existing in certain tissues of the body. Such a colony of poison-producing germs is called a focal infection or focus.

There are three distinct types of rheumatism:

- (1) Rheumatism of the joints ("arthritis") which occurs in two forms: (a) Acute arthritis or acute rheumatic fever (b) Chronic arthritis.
- (2) Rheumatism of the nerves ("neuritis").
- (3) Rheumatism of the muscles ("myositis").

If the toxin produced by a focal infection causes inflammation of a joint, the result is arthritis; if it attacks a nerve, the result is neuritis; and if it affects a muscle, the result is muscular rheumatism.

It must be distinctly understood that in all these types we are dealing with essentially the same disease, namely, rheumatism, which does not change its nature, whether it affects a joint, a nerve or a muscle. Naturally, a pain in a joint is different in character from a pain in a nerve or muscle; and the gradual destruction of a joint will produce symptoms which have hardly anything in common with those found in a mild attack of neuritis.

The discovery that bacterial poison is the cause of rheumatism points at once to an effective and simple

* *GERMS* is merely the English word for *bacteria*. In using either of these expressions in this book, I am always referring to germs of a disease.

way to treat this disease. It is obvious that, if the toxin is removed from the blood, the rheumatism must disappear. The best way to accomplish this is by removing the source of the toxin, the focal infection. Such a treatment, striking at the cause of a disease, is called "causal treatment," as contrasted with "symptomatic treatment," which merely relieves the symptoms without effecting a cure.

Infected teeth and tonsils are frequent sites of focal infection. In rheumatism, however, removal of the teeth or tonsils is often not sufficient to effect a cure. It must be supplemented by removal of the infection in the veins.

My attention was first called to the connection between phlebitis and rheumatism by the fact that a great number of patients whom I treated for chronic phlebitis (inflammation of the veins) were also suffering from rheumatism. In many cases I was able to trace the infection in the veins of the legs to a concealed infection in the jugular veins. In some cases the jugular vein infection acted as a "feeder" for the infection in the veins of the legs. In all these patients who suffered from phlebitis and rheumatism at the same time, I observed that the cure of the phlebitis was always followed by a decided improvement of the rheumatic condition, which in most instances disappeared completely, although there was no local treatment of rheumatism.

In phlebitis, we have an infectious region within the wall of the blood vessels. Therefore the poison pro-

duced by these germs goes directly into the bloodstream, which naturally spreads it all through the body. Thus it can be easily understood why an infection of the veins may be the direct cause of a rheumatic pain in the shoulder. The place where one feels pain may have nothing to do with the location of the trouble that produces the pain.

The famous French physician, M. Audier, writes in his book, *Le diagnostic des phlébites des membres*, published in 1935: "Souvent nous avons vu se développer un rhumatisme chronique progressif a la suite d'une phlébite banale." (Often we have seen progressive chronic rheumatism develop after a simple phlebitis).

C. L. Schmidt, Koehler and other authors confirmed in medical literature my conception about the relationship of phlebitis to rheumatism.

My experience has shown me that removal of the infection in the veins produced very good results in acute rheumatic fever, sciatica, lumbago and other rheumatic afflictions.

Most foot troubles are caused by phlebitis in the legs and respond very well to the removal of the infection in the veins.

CONCLUSION

Practically all forms of rheumatism are caused by an infection that produces septicemia (blood poison-

ing). Septicemia means that from a point within the body (teeth, tonsils, jugular veins or leg veins) germs or poisons (toxins) produced by the germs enter the bloodstream and cause symptoms of diseases.

The most important infection that causes rheumatism is latent (concealed) phlebitis. This latent inflammation in the walls of the vein is the point where toxins are produced. The joints, the nerves and the muscles are the points where the toxins attack. From the point of production the toxins are carried to the point of attack by the blood.

Rheumatism, formerly thought of simply as a disease of certain joints, nerves or muscles, is only a symptom of a septic condition (blood poisoning) that affects the whole body. This point of view has completely changed ideas of treatment.

CHAPTER VII

CONGESTION OF THE HEAD

*Experience becomes the greatest test of truth
and is perpetually contradicting theories of men.*

Samuel Johnson

INTRODUCTION

A large number of ailments of the head defy medical treatment. Especially noteworthy among these are sinusitis, trifacial neuralgia, noises of the ear, head noises, deafness or impaired hearing without apparent affection of the ear nerve, and headaches without de-

terminable cause. These conditions occur frequently and are a source of great suffering for the patient.

Some other diseases which, fortunately, are comparatively rare but much more dangerous, are located in the head and have been practically incurable until now. Among them are encephalitis lethargica, commonly known as sleeping sickness, and certain diseases of the meninges and the brain.

Hemorrhages involving the eye, acute and chronic inflammation of the iris, glaucoma, chronic mastoiditis, chronic stomatitis (often referred to as canker sores of the mouth) pyorrhea, chronic colds located in the upper respiratory tract, neuralgic pains in the region of the head, nose bleeding in patients with high blood-pressure, vomiting caused by irritation of the vomiting center in the brain, and many other disorders of the head belong to the same category. They either do not respond favorably to the commonly used therapeutic measures, or heal very slowly with frequent recurrences.

Some allergic conditions, especially hayfever and asthma, that are not caused by a traceable disease in the region of the lungs or brought on by such mechanical obstructions as polypous growths in the nose, can hardly ever be permanently relieved by ordinary methods of treatment.

Why are these conditions apparently immune to every generally used method of treatment?

This perplexing problem intrigued me from the

time I began to practice medicine. Persistent study of the medical literature related to this subject, close observation of my patients, and visits to clinics here and abroad where I could observe large numbers of patients suffering from one or more of the above enumerated diseases finally convinced me that the solution of this problem was to be found in a condition which, until then, had been completely overlooked, namely, in congestion of the head. In the following chapter I shall show why these conditions cannot be treated successfully by ordinary methods which do not remove an existing congestion of the head.

CAUSE OF HEAD CONGESTION

Congestion of the head is caused by jugular phlebitis. The inflammation produces a swelling of the wall of the affected vein, especially of the inner coat. The inflammatory swelling destroys the smooth and thin inner lining of the blood vessel replacing it with a rough, irregular, and much thicker surface. The changes taking place in an inflamed vein are not unlike those existing in a rusty pipe line. Therefore, the blood has less space through which to flow because of the swelling, and it must overcome increased friction due to the roughness of the surface. As the jugular veins constitute practically the only connection between head and heart, the result is incomplete drainage of venous

HEAD NORMAL CIRCULATION

HEALTHY
JUGULAR VEIN

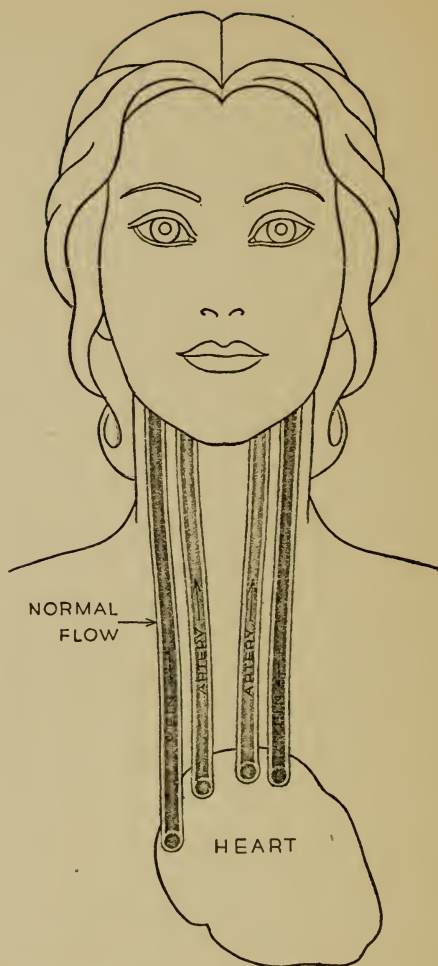
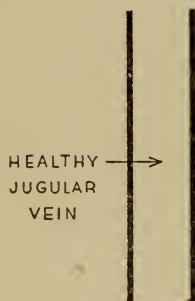
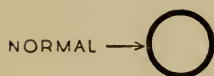


FIGURE 4.

This schematic drawing shows normal circulation in blood-vessels of the neck.

blood from the region of the head. An abnormally large amount of venous blood accumulates gradually during the course of the disease and eventually causes congestion of the head. In other words, venous blood that should go through the heart to the lungs for purification stays in the head.

EFFECT ON TISSUES

(a) *Pressure*: Once congestion of the head is fully developed, all the veins of the head, including the venous portion of the capillaries, are filled to the limit of their capacity with venous blood. That means they are maximally enlarged and therefore take up much more space than under normal conditions, exerting a continuous abnormal pressure on the surrounding tissues. Dr. H. A. E. van Dishoeck of the University of Amsterdam, has shown that the amount of blood in the mucous membrane of the nose is directly dependent on the carrying capacity of the jugular veins, by measuring the pressure of the blood in the nose before and after compressing the jugular vein. Compression of the jugular vein prevents the blood flowing back to the heart, and the apparatus which he inserts into the nostrils promptly registers increased pressure equivalent to the increased amount of the retained blood. When the compression of the jugular vein is relieved, the pressure in the nose returns to normal. The medical

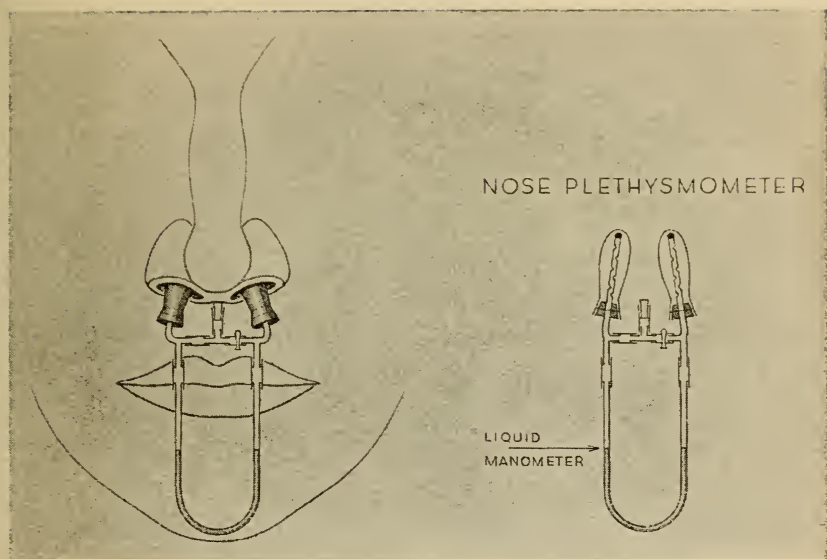


FIGURE 6.

term for the procedure is plethysmometric measurement. If van Dishoeck can show that compression of the jugular vein increases the amount of blood in the nose, it is simply logical to assume not only that a similar congestion must exist in the whole area of the head, but also that jugular phlebitis with its narrowing of the vein canal, has the same effect on the carrying capacity of the jugular veins as compression from the outside, and therefore causes congestion of the head.

Another proof of the correctness of this assumption is the Queckenstedt phenomenon, which shows that the pressure of the spinal fluid can be increased by

compressing the jugular veins. The compression of the jugular veins from the outside narrows the diameter of the vein in the same way as a swelling of the inner wall of the vein. The spinal fluid is a part of the fluid that surrounds the brain and spinal cord and fills the communicating cavities of the brain that are continuous with the central canal of the spinal cord. Any increase of pressure in the region of the head, therefore, must produce increased pressure of the spinal fluid; if compression of the jugular veins produces increased pressure of the spinal fluid, one must assume that this is possible only by way of increased venous pressure in the whole region of the head.

Congestion of the head, therefore, means abnormally increased pressure on the tissues of the head. Continuous pressure is damaging to all tissues, but it is especially injurious to the highly sensitive brain tissue.

(b) *Effect on metabolism of tissues.* The pressure of an abnormally large amount of venous blood in the head, and the slow, sluggish backflow to the heart, prevent the inflow of a sufficient amount of arterial blood. This leads to weakening and undernourishment of all the exposed tissues, because the arterial blood cannot deliver the constantly needed oxygen and nourishing materials which it carries to the cells of the tissues. The venous blood, on the other hand, cannot carry away the poisonous waste material quickly

enough, due to its slow motion. In congestion of the head, therefore, the tissues lack nourishment, and are choked by their own waste products.

Now we can understand why the famous pathologist, Professor Dr. Otto Lubarsch, regarded every congested area in the body as a "*locus minoris resistentiae*", that is literally translated, "a place of decreased resistance", meaning resistance against any disease-producing agency, such as germs, toxins, exposure to climatic influences, and others. The tissues of the head when exposed to congestion are damaged by pressure, poisoned by waste material, and weakened by lack of nourishment and oxygen. In addition to all this, they are exposed to the injurious activity of toxins produced by the same infection that causes the congestion, namely, the jugular phlebitis. No wonder they succumb to a number of diseases much more frequently than normal healthy tissues.

A clear understanding of the consequences of congestion of the head shows why many diseases located in the head, as, for example, sinusitis, have a tendency to become chronic and to be unresponsive to commonly used methods of treatment. The tissues simply do not have enough reserve power left to throw off the disease, and to respond to treatment.

The effect of congestion on the tissues also explains the peculiar fact that, as we shall see, so many different diseases which are apparently entirely unrelated can

be alleviated successfully by removing the one and only cause, namely, congestion of the head due to jugular phlebitis.

RHEUMATIC CONDITIONS IN THE REGION OF THE HEAD

Rheumatism of the head occurs as muscular rheumatism, rheumatism of the nerves or neuralgia, and rheumatism of the joints or arthritis. Idiopathic neuralgia of the trifacial nerve is one of the most painful diseases known to medicine. The excruciating pain may drive the patient to thoughts of suicide as the only way to find permanent relief, since all commonly used methods of treatment bring, as a rule, only temporary and partial improvement, because they do not remove the cause of the disease which is to be found in congestion of the head due to jugular phlebitis. Even radical operations, such as removal of the whole nerve, do not guarantee success in every case. An abstract of the author's paper on Trigeminal Neuralgia appeared in *The Journal of the American Medical Association*, August 14, 1937, page 543.

The first patient treated for infection of the jugular veins, a man thirty years old, had suffered for ten years from violent attacks of trifacial neuralgia which occurred at frequent intervals and often incapacitated

him for days. Following the removal of the congestion of the head, by eliminating the causative jugular phlebitis, the neuralgia disappeared and the patient has now been free from attacks for several years. Recently, a Dutch doctor reported, in a letter to me, excellent results in similar cases. Subsequently, I found that almost every patient suffering from trifacial neuralgia also had congestion of the head due to jugular phlebitis. The same conditions prevail in other forms of rheumatism, as, for example, rheumatism of the neck ("stiff neck"), occipital neuralgia, arthritis of the joint of the jaw, arthritis of the joint between the first vertebra and skull, and rheumatism of the muscles of the head. All cases of this kind can be treated successfully by removing the congestion of the head.

Of course, I am referring only to cases in which the focus is situated in the jugular veins. There are cases of rheumatism in the head without congestion of the head, and cases of other diseases caused by other foci, for example by phlebitis of the legs. These, however, are the exception rather than the rule.

SINUSITIS

Chronic sinusitis develops almost entirely on the basis of a congestion of the head, and it persists as long as the circulation of the blood is not restored to normal. For this reason many patients believe that this condi-

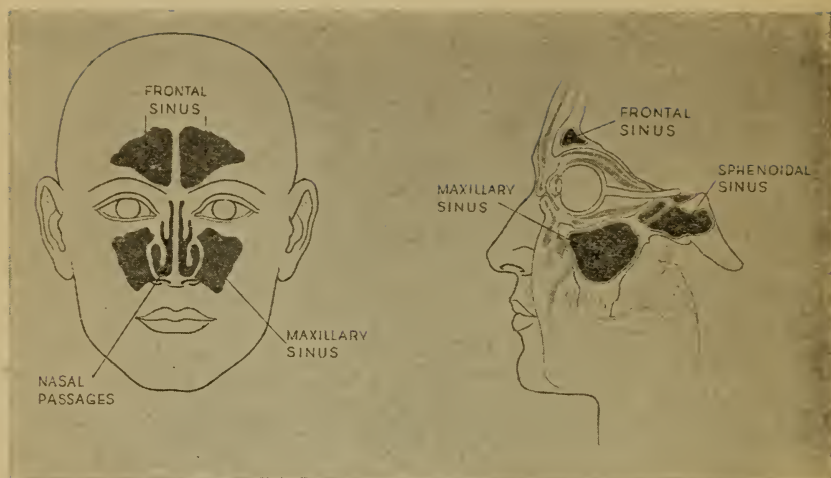


FIGURE 7.

tion is incurable. It is an old saying: Once a sinus patient, always a sinus patient. Temporary relief is the best that many people suffering from this condition expect. Since we can show that chronic congestion of the head due to jugular phlebitis is the one thing that prevents sinusitis from healing, the state of these patients is no longer hopeless. In fact, a successful treatment can be effected in most cases with hardly any loss of time and with a minimum of discomfort, as no operative measures are involved in the removal of jugular phlebitis. What can be done for so-called incurable sinus patients is best illustrated by the case of a thirteen-year old girl who suffered for years from chronic sinusitis. A friend of the family who interested himself

in the unfortunate child sent her to me for consultation. Examination of the jugular veins disclosed a pronounced chronic infection of these blood vessels. There was no infection to be found in the teeth and tonsils. After one treatment the sinusitis cleared up, and the little girl is now free of discomfort. Recently I treated a physician, the chief surgeon of a large hospital, who had been suffering for years from chronic inflammation of the sinus cavities and chronic blepharitis (inflammation of the eyelids). After one treatment of the jugular veins the pain in the sinus region stopped, and the eyelids became normal. Of course, in every case of sinusitis the patient must be examined thoroughly, in order to make sure that no focus is present other than that in the jugular veins. Should there be another source of infection, it must be removed before treating the jugular veins because otherwise it is possible that the jugular veins may become reinfected from a focus in the tonsils or teeth, or elsewhere in the body.

SOME OTHER CHRONIC CONDITIONS DUE TO CONGESTION OF THE HEAD

Chronic colds in the upper respiratory tract, acute laryngitis, chronic laryngitis (hoarseness) ulcerative processes in the nose, and similar conditions, are also often caused, or prevented from healing, by infection of the jugular veins.

Chronic stomatitis, an ulcerative inflammation of

the mouth that is often referred to as "canker sores", heals promptly if an existing congestion of the head is removed by clearing up the causative jugular phlebitis.

In pyorrhea, examination of the jugular veins often discloses jugular phlebitis, the removal of which greatly speeds recovery. I am convinced that many cases of pyorrhea could be prevented if an existing congestion of the head were removed in time. The earlier the treatment starts, the better the result will be.

Other chronic conditions caused by congestion of the head, in which excellent results were obtained merely by clearing up an existing chronic jugular phlebitis are noises in the head, spells of dizziness, insomnia, swelling of the face without specific cause, certain diseases of the ear (such as ear noises, impaired hearing and deafness provided the ear nerve is not destroyed), inflammation of the middle ear, chronic mastoiditis (which responds very quickly to this treatment), hemorrhages within the eye, and chronic iritis.

A few case histories may illustrate what can be done in such cases. Some types of deafness respond very well in many cases to the removal of the infection in the jugular veins. The first patient treated for deafness was an old lady in Sands Point, L. I., who was the cousin of the most famous brain specialist in America. She had become deaf after an attack of grippe. Within a day after the treatment the hearing became normal. A school teacher who was dismissed

because she was hard of hearing responded so well to the treatment that she was reinstated in her work. A child, about 6 years old, a deafmute since birth, was able to hear and to speak after the first treatment, and is now able to pronounce a few hundred words. Her ability to speak is improving from week to week.

A noted research chemist from Vienna, who had consulted the most famous ear specialists of the University of Vienna for deafness in his left ear, wrote me, after removal of the causative infection the following letter: "Just a word to let you know that I am experiencing remarkable recovery with my left ear, and that I can hear quite well now."

Another patient whom I treated for arthritis by removal of the concealed infection in his jugular veins had been hard of hearing for many years. He always used to put his hands behind both ears to hear better. After the treatment the hearing became completely normal.

A boy, 12 years old, became deaf after scarlet fever and had to learn lipreading. After removal of his infected tonsils and a short treatment of the jugular vein infection his hearing became completely normal.

A middle-aged man who had suffered from chronic inflammation of the eyes (rheumatic iritis) since boyhood, and who had been treated in the best hospitals here and abroad without result, has been cured by removing an existing chronic infection of the

jugular veins, and has had no relapse for three years.

The author of this book suffered from acute blepharitis (inflammation of the eyelids) and severe eczema of the face. The removal of the infection of the jugular veins cured the condition in a short time.

Last year a nurse who had been suffering for years from ptosis (paralytic drooping of the eyelid) was given this treatment after all other treatments had failed; the condition was remedied after the infection of the jugular veins was removed. A patient who suffered from Menière's disease was relieved of dizziness, vomiting and ear noises, in a short while, by removal of the infection in the jugular veins.

A woman suffering for about five years from severe headaches and vomiting spells consulted me after a brain surgeon had made an exploratory operation of the brain because he suspected a brain tumor. After removal of the congestion of the head she was completely relieved of her symptoms.

As I considered that the vomiting spells were caused by a congestive irritation of the vomiting center I concluded that other nerve centers in the same brain area (medulla oblongata) might be irritated in the same way. A center is a collection of nerve cells which is concerned with a special function. Besides the vomiting center there is a respiratory center in the medulla oblongata which coordinates the breathing movements. Its disturbance can cause asthma.

Another center in the medulla oblongata is the

convulsion center. Its stimulation by congestion may cause convulsion. The coughing center in the same area presides over the act of coughing.

From any textbook on physiology we can learn that a venous congestion can irritate these centers.

Persistent headaches of otherwise unknown origin respond extremely well to the treatment. A physician in Holland, who had read my papers on this subject in medical journals, wrote me the following interesting letter :

"I have read your paper about latent jugular phlebitis, and was very much interested in your observations. As a general practitioner, I often see patients with mild forms of phlebitis following tonsillitis, without the dangerous form of tonsillogenic septicemia. I noticed more than once that after recovery they often complained of indefinite pains in the neck with a tender spot on the jugular vein. Now I know from your communication that the phlebitis may be still there.

"It will interest you to know that after reading your paper I made the following observation : A young man, age 25, had headaches for years and was treated by a throat specialist for a mild form of tonsillitis and the specialist, therefore, would not perform a tonsillectomy. During the last months his headaches grew worse and took a serious form. Every other day, in the morning from 8 to 12, he had such pains that he was prostrated, had to go to bed, and could not work. In the afternoon he was all right and he continued working.

In my consulting hour he visited me, and I found a painful swelling in the middle of the jugular vein; very painful on pressing. But what was most important was this, namely, that when I compressed lightly the painful spot, he immediately noticed the same radiating pain in his head, as in the spontaneous attacks. But there was yet another symptom. During his attack it was always noticed that the superficial veins of his face on the same side as the jugular swelling were prominently swollen. When I lightly pressed the jugular vein I could see the same veins distending and falling flat after the light pressing was stopped. So I could prove in this case by his subjective sensations and by this objective sign that your theory about the 'venous congestion' was right. I treated him. The phlebitis disappeared absolutely; so did his headaches and the 'pressing symptoms', subjectively and objectively. What is more, after the treatment, he stated that he could concentrate better, was more lively, and could differentiate colors much better than for years past.

"So far as I know, attention has never been called, in the Dutch literature, to this subject, so that I purpose at least to write a paper about it. You would oblige me very much if you could send me reprints of your papers on this subject, so that I may refer to them in extenso."

The same physician reported in a letter of October 6, 1939, that he had treated successfully with this method, a case of headache on one side, and a case of trigeminus neuralgia.

A physician, who is a well-known biological research man, was treated for migraine from which he had been suffering for many years. After the removal of the jugular vein infection the migraine disappeared completely.

DISEASES OF THE CENTRAL NERVOUS SYSTEM CAUSED BY CONGESTION OF THE HEAD

It is an interesting fact that in most cases of encephalitis lethargica, commonly called sleeping sickness, congestion of the head, due to chronic concealed phlebitis, can be found. A number of patients suffering from this condition have been treated by removal of the infection in the jugular veins, thereby eradicating the congestion of the head, and the results obtained with this method have been very satisfactory. In considering the fact that the brain, a tissue which is extremely sensitive to changes in pressure, is fitted to the skull like a complicated key to its lock, the damaging effects of a venous congestion of the head are easily understandable. Because the bony skull is not elastic, a congested brain is exposed to pressure and must suffer damage. For the same reason, therefore, the only logical treatment in these cases must consist in removing the congestion of the head, thereby making it possible for the delicate tissues of the brain to combat the disease.

The most favorable time for the application of the treatment is, in my opinion, at the very onset of the disease, in order to prevent permanent damage to the brain.

I also obtained favorable results in cases of chorea or St. Vitus dance, and of epilepsy in which congestion of the head was present. The prompt response of the patients to removal of the jugular phlebitis justifies the assumption that, in these cases, the causative factor is to be found in the action of the toxins on the basis of the decreased power of resistance of the affected tissues due to increased pressure. It is possible that, in chorea, the action of the toxins is predominant, while in epilepsy, in most cases, the pressure plays the main role in causing the disease.

What can be accomplished by decongestion of the head seems almost unbelievable. A child of 11 years of age suffering from St. Vitus dance was recently brought to my office. The child was very restless and nervous. Her muscular movements were incoordinated, involuntary and jerky. Spasms of the face caused peculiar grimaces. The legs were so much involved that she stumbled. She had severe speech disturbances. Her speech was explosive and she spoke in broken sentences. She complained about severe insomnia. Her appetite was poor. She was melancholic because the other children ridiculed her and refused to play with her. After removal of the jugular vein infection the child became completely normal in less than a week.

This child had been treated without any result by other methods for several years.

In my opinion, congestion of the head due to jugular phlebitis will play an important role in the future development of psychiatry. If acute infections like grippe or pneumonia can cause temporary mental disturbances, it is logical to assume that chronic infections may have the same effect, especially if the circulation of the brain is directly disturbed by a local congestion due to a chronic infection of the jugular veins.

Most cases of extreme nervousness and neurasthenia (a nervous disorder characterized by extreme fatigability) respond immediately to the removal of infectious foci in the jugular veins. Also, patients suffering from insomnia (sleeplessness) reported improvement after the treatment of the jugular veins.

CONCLUSION

Jugular phlebitis causes congestion in the head and produces toxins; the congestion weakens the tissues which then cannot successfully withstand the action of the toxins; once the disease has taken root it cannot heal as long as the congestion keeps the tissues in a weakened condition and the flow of toxins continues uninterrupted; removal of the jugular phlebitis eliminates the congestion and stops the production of toxins; then the tissues recover their normal vitality and are able to overcome the disease; and, finally, recovery is complete because the source of toxins is eradicated.

CHAPTER VIII

FOCAL INFECTION AND ALLERGY

A physician who is very much interested in the subject of allergy wrote under the title *A New Approach to Asthma, Hay Fever and Eczema* the following article:

"Allergy is a term used to describe certain unusual reactions that are peculiar only to hypersensitive individuals. In other words, some people are affected by substances which are harmless to normal persons.

"These unusual reactions may be manifested as asthma, hay fever, eczema, vasomotor rhinitis and similar disturbances.

"In one of the latest issues of *The Journal of the American Medical Association* appeared a criticism of a book on allergy. After reviewing this book the critic comes to this conclusion: 'The problem of treat-

ment of allergic diseases as well as details of the pathogenesis are not well understood. Perhaps these problems may be solved from some physical or chemical discovery by workers in fields apparently remote from medicine but still pertaining to the workings of the living cell. Thus our understanding of allergy may be entirely changed and the appearance of the allergic state may become no more than an occasional curiosity. The family of allergic diseases may then become merely an interesting episode in medical history.'

"The old Roman doctors used to say '*Ars tota medica in observationibus*', which means that the whole medical science is based on observation. By observing the general effects of a local treatment, we frequently find reactions in other parts of the body which point the way to the discovery of new and effective methods of treatment.

"I had an opportunity to interview several patients who had suffered for many years from hay fever and other allergic symptoms. They all told me that after a complete removal of a concealed infection in the jugular vein they had no longer suffered from hay fever. Some of these patients have been free from hay fever for four or five years. These patients did not undergo treatment for hay fever, but mostly for arthritis, neuritis and other rheumatic symptoms. They were treated for the symptoms by the New York phlebitis specialist, Dr. Otto Meyer, who has a new conception of focal infections. He maintains that besides infected teeth or

tonsils the most important sites of focal infection are in the veins of the human body. In the past many teeth and tonsils have been removed without any benefit to the patient. He discovered a few years ago that in such cases there existed a concealed infection in the jugular veins.

“In cases of eczema which were supposed to be allergic, he found that removal of the congestion in the eczematous areas checked the eczema. Eczema of the head disappeared quickly after the treatment of the jugular vein. Eczema of the hands and fingers disappeared when he treated inflammation of the subclavian vein. This part of the venous system is located behind and under the collar bone. The swelling of this vein makes it impossible for the venous blood of the arms and hands to flow freely through the jugular vein to the heart. The result is a congestion of the whole arm region. In eczema of the legs he treats the concealed infection in the leg veins that carry the blood from the legs to the heart and so accomplishes a normal drainage of the leg area. Dr. Meyer described this kind of eczema about ten years ago in the *Vienna Medical Journal* as ‘Phlebitic Eczema,’ a term which was not known in medical terminology. The patients so treated refer humorously to Dr. Meyer’s work as ‘medical plumbing.’ In no case of eczema did Dr. Meyer treat the local area with ointments, lotions, x-ray, or other kinds of the customary local treatments for eczema, and

proved thereby that the eczema was nothing else but a symptom of phlebitis."

In investigating congestion of the head I observed the favorable reaction of certain allergic conditions to removal of an existing jugular phlebitis. A satisfactory explanation of these cases is not easy. Persons susceptible to hay fever have a certain inborn degree of hypersensitivity to definite pollens. However, this does not mean that they must succumb to hay fever every time pollen settles on the mucous membrane of their noses. I firmly believe that the natural defensive power of the tissue in the majority of these individuals is able to overcome the effect of the pollen if given a chance, that is, if no other disturbing factors enter the picture and weaken their power of resistance. A congestion of the head does precisely this. As I have explained in detail in preceding paragraphs, both the congestive action and the activity of the toxins decrease the power of tissues to resist diseases of any kind. If this is so, why then should an allergic condition be an exception?

Furthermore, if our contentions are correct, the mucous membrane in persons susceptible to hay fever has from the beginning very little or no reserve resistance. Therefore, a slight disturbance is sufficient to upset the delicate balance that decides between health and disease. It is my contention that congestion of the head furnishes this disturbance. As proof of the correctness of my theory, I offer the fact of having relieved a number of patients from their allergy to pollens mere-

ly by removing an existing congestion of the head, without using any other supporting treatment. Among the patients cured in this manner are a number who have been treated with pollen antigens for years with varying but never complete success.

Asthma due to an allergic condition also responds favorably to removal of infection in the jugular veins. I treated several physicians who suffered from bronchial asthma for years. They responded promptly to the treatment and have had *no relapse*.

Bronchial asthma in many cases seems to be caused by a congestion of the breathing center in the brain which controls the breathing mechanism.

Any substance which is capable of inducing or exciting a condition of allergy or specific susceptibility is called allergen. The human body may come in contact with the allergens through the skin or mucous linings, the intestines, or by inhalation.

Purified allergens are used to determine whether a patient is sensitive to certain substances. In hay fever we have different types according to the season. The spring type of hay fever is almost always due to tree pollens, the summer type to pollens of grasses, and the fall type to pollens of ragweeds; the fall type causes more hay fever than the other two groups combined.

Asthma due to pollen sensitivity may occur without the usual symptoms of hay fever, may be present with hay fever, or may develop as a complication of hay fever. The development of a cough in a hay fever

patient during the middle or toward the end of the season should arouse suspicion of asthma as a complication.

EXAMPLES OF ALLERGIC REACTIONS

A patient was allergic to fish. She never ate fish, but she was so sensitive that the odor was sufficient to cause skin eruptions. After removal of the vein infection she was able to eat fish without trouble.

A lady, about 30 years old, was treated successfully for sinus trouble by removal of the infection in her jugular veins. She did not mention that she had been suffering from hay fever for 8 years. After treatment, five years ago, she had no more hay fever.

A pastry cook, about 40 years old, was suffering from bronchial asthma and weeping eczema of both hands. He was supposed to be allergic to flour. After extraction of 3 dead teeth, and after removal of the concealed infection in his jugular veins, the eczema disappeared without any local treatment of the skin affliction. His asthma attacks stopped promptly.

A young man developed asthma while working in a face powder factory. He was supposed to be highly allergic to face powder. After removal of one dead tooth and removal of the concealed infection in his jugular veins the allergy to face powder and his asthma disappeared.

The dust of a house, the roses in a garden, animal

fur, feathers, grasses, eggs, strawberries, are among the most common substances that cause some people to break out with hives or hay fever, asthma or eczema, rhinitis or migraine.

A friend of mine developed asthma when he touched a horse. After removal of his jugular phlebitis his allergy disappeared.

A well known mining engineer was suffering from a very annoying eczema and itching in the anal region. Local treatments with lotions, ointments and x-rays showed no results. After removal of the concealed focal infection in the jugular veins and the deep leg veins, he was free from eczema and itching.

So far, medical science has been able to give a fairly accurate explanation of how allergy works, but it could not explain why persons become sensitized to certain substances. The final solution seems to be found in a state of toxinemia that causes a person to be allergic.

In my opinion skin testing will be discarded in the future treatment of allergy, since it is now known that toxinemia prepares the soil for allergic reactions.

CONCLUSION

Toxinemia, which means a mild poisoning of the blood with toxins which are manufactured in concealed foci of infection, especially in concealed inflammation of the veins, predisposes strongly to allergic conditions.

CHAPTER IX

FOCAL INFECTION AND HIGH BLOOD PRESSURE

"Normal" blood pressure is considered as the average blood pressure in persons of a given age. "High" blood pressure, for which the medical term is hypertension, means abnormally increased blood pressure.

We distinguish two forms of high blood pressure, namely, high blood pressure due to definitely known causes such as certain chronic diseases of the kidneys, and "essential" high blood pressure (essential hypertension), which means high blood pressure without a demonstrable cause. Essential hypertension was first recognized by the great English physician Sir Clifford Allbutt, in 1895. He observed high blood pressure in

patients who had no clinical symptoms of kidney disease.

This chapter deals only with essential high blood pressure and proposes to show that, contrary to the prevailing medical opinion, a definite cause of this condition exists, which can be readily recognized and easily removed.

There have been many theories on the cause of high blood pressure, but all have failed to give a satisfactory explanation of this condition. In my opinion, this is solely due to the fact that research has persistently underestimated the role of the vasoconstrictor center in the brain which controls the blood pressure in the arterioles. The arterioles are the smallest arteries in the body which connect the larger arteries with the capillaries. The vasoconstrictor center sends nerve fibers to the small arterioles. These vasoconstrictor fibers stimulate the muscular coats of the blood vessels to contract. The action of the vasoconstrictor center maintains a normal tone in the blood vessels. Tone means a slight contraction of the muscles in the blood vessels by means of continuous slight stimulation brought to them by the vasoconstrictor nerves. If the small arterioles are more than normally contracted, they offer increased resistance to the outflow of blood from the heart. In order to maintain the circulation of the blood, the heart muscle has to increase its pressure on the outflowing blood, with the result that the blood pressure rises. In other words, abnormal contraction of the walls of the

small arterioles causes increased blood pressure. But the state of contraction in the small arterioles is controlled by the vasoconstrictor center in the brain. Therefore, abnormal stimulation of the vasoconstrictor center in the brain increases the blood pressure. It is my opinion that so-called "essential" high blood pressure is always caused by an increased stimulation of the vasoconstrictor center. The most common cause of stimulation of the vasoconstrictor center is a venous congestion of the brain, that is, an abnormally large accumulation of impure blood in the veins of the brain. Landois, Mathisson, and other research workers, have shown that increased accumulation of venous blood in the brain stimulates the vasoconstrictor center and thereby causes increased contraction of the small arterioles which, as we have seen, produces high blood pressure.

Venous congestion of the brain is caused by lack of drainage. The drainage of the whole region of the head is accomplished by means of the jugular veins which carry the blood from the head to the heart. If we compare the jugular vein with a rubber tube, we can readily imagine a way of disturbing the free flow of a liquid that passes through this structure. By increasing the thickness of the inner wall we decrease its caliber, that is, the diameter of the bore of the tube, thereby impairing its carrying capacity. The same effect is apparent in a pipe-line which has become corroded. A condition, therefore, which decreases the caliber of the

jugular veins is bound to prevent the free flow of venous blood from the head to the heart, and cause a venous congestion in the brain. The most common condition of this kind is an inflammation of the jugular veins (jugular phlebitis). As there is no inflammation without a swelling of the involved tissue, jugular phlebitis (inflammation of the jugular veins) causes a narrowing of the vein canal, thereby preventing the free flow of blood from the head to the heart, and eventually resulting in a venous congestion of the brain. The venous congestion stimulates the vasoconstrictor center in the brain, and so increases the blood pressure. My experience has convinced me that jugular phlebitis, by its effect on the vasoconstrictor center, is the cause of most cases of so-called essential high blood pressure.

The logical treatment, therefore, of essential high blood pressure is the removal of the jugular phlebitis which, as we have seen, is the most frequent cause of this condition. However, before treating the jugular veins it is necessary to remove all infections in the mouth that "feed" the infection in the jugular veins. Especially important is the removal of infected teeth. Furthermore, dead teeth must be removed, whether or not they cause any discomfort to the patient, because practically every "dead" tooth in which the nerve has been killed is found to be infected, as Professor Oliver T. Osborne of Yale University explains so impressively in his book *Mouth Infection*. Just as important, of course, is the removal of infected tonsils.

The fact that essential high blood pressure is caused by a disturbance of the vasoconstrictor center reduces its status of an independent disease of unknown origin to that of a mere symptom of jugular phlebitis. This knowledge makes it possible to treat it effectively, and thereby save many patients from the dire consequences of high blood pressure.

CONCLUSION

Essential hypertension, that is, high blood pressure without a demonstrable cause, is in many instances due to increased stimulation of the vasoconstrictor center in the central nervous system. The increased stimulation of the vasoconstrictor center is caused by a venous congestion of the brain. The venous congestion of the brain is caused by jugular phlebitis, as described in this chapter. Therefore, in these cases, the hitherto hidden cause of essential hypertension is an inflammation of the jugular veins, that is, jugular phlebitis.

CHAPTER X

CAN INFANTILE PARALYSIS BE PREVENTED?

Theory must evolve from practice and not vice versa.

Paracelsus

The term "infantile paralysis" is misleading for the disease, because it occurs sometimes in adults, and paralysis does not always supervene. The malady has been described by somewhat cumbrous names. It is scientifically known as acute poliomyelitis. Poliomyelitis has been described by Simon Flexner as "one of the saddest diseases". Dr. Thomas Buzzard characterized it as being "peculiarly cruel to its hapless victims". It leaves many of the survivors permanently paralytic and crippled. The majority of the sufferers are young children.

Poliomyelitis means inflammation of the gray substance of the spinal cord. A pathologist who bases his knowledge upon postmortem findings would call this disease correctly meningo-encephalo-myelitis. In postmortem examinations of a victim of this disease, the pathologist finds signs of meningitis, an inflammation of the meninges, which are the membranes that envelop the brain and the spinal cord, signs of encephalitis (inflammation of the brain), and signs of myelitis (inflammation of the spinal cord).

Some scientists believe that the cause is a specific virus or a streptococcus. Dr. Charles E. Rosenow of the Mayo Clinic at Rochester (Minn.) believes that the streptococcus germs may be the cause of infantile paralysis, and cites laboratory tests tending to prove it. He has evolved the theory of a change in a hypothetical life cycle from streptococcus viridans into a "virus phase" and back again. Many physicians are of the opinion that poliomyelitis is a general infectious disease with a secondary involvement of the central nervous system.

Most cases of poliomyelitis start with a sore throat. It is interesting that operative removal of the tonsils (tonsillectomy) sometimes provokes a concealed (latent) infection in the jugular veins and thereby causes septicemia (poisoning of the blood). Also acute poliomyelitis with ensuing infantile paralysis sometimes follows operative removal of the tonsils. Faber compiled from the literature 73 cases in which this hap-

pened. It seems that, in these cases, the tonsil area is the port of entry of the causative agent of poliomyelitis. Stillerman and Fischer warn that tonsillectomy and adenoidectomy should not be encouraged during an epidemic of poliomyelitis.

The most suggestive manifestations for a diagnosis at the beginning of poliomyelitis are meningeal symptoms of increased intracranial pressure, (pressure within the skull) such as stiffness of the neck, vomiting, somnolence, and a positive Kernig's sign.

Increased pressure of the spinal fluid is found in nearly all patients suffering from poliomyelitis, as reported by Weber and Schmidt of the University Clinic for children's diseases in Berne (Switzerland), and Mueller and Roemer observed that withdrawing cerebrospinal fluid had a good effect on poliomyelitis patients.

Dietrich found degenerated ganglion cells in the spinal cord which did not show any signs of inflammation. He believes that their destruction is caused by the effect of toxins. In these cases one must assume that the toxins have a neurotropic tendency. It is therefore possible that the destruction of at least part of the tissue in the spinal cord is due to the action of toxins which are produced in some other part of the body. We find that most authors agree with regard to the following facts:

1. Poliomyelitis begins with cerebral pressure symptoms

2. The pressure of the spinal fluid is usually increased
3. The destruction of the ganglion cells which causes the paralysis is in many cases not due to inflammatory changes, but to the action of toxins

Based upon my observations in treating encephalitis, I am convinced that the relief of the pressure in the central nervous system is of utmost importance in treating poliomyelitis. In encephalitis the intracranial pressure is increased. The patients whom I treated suffered from a chronic jugular phlebitis. This condition increases the pressure in the brain due to insufficient drainage as explained in previous chapters. Removal of the jugular phlebitis immediately relieved the abnormal intracranial pressure and was accompanied by a dramatic improvement of the patient, followed by gradual recovery. The effectiveness of this treatment is due to removal of the intracranial pressure. The increased pressure decreases the power of resistance and prevents the recovery of the sensitive nervous tissue. If it is removed the nervous tissue has a much greater chance to overcome the inflammation caused by germs, and most of all to resist the injurious influence of the toxins.

A few years ago I had occasion to observe many poliomyelitis cases during one of the most widespread epidemics in Europe. I examined a large number of patients and found that almost all of them suffered from concealed jugular phlebitis. This condition in-

creases the pressure in the brain and in the spinal fluid as shown by the Queckenstedt phenomenon, which demonstrates that the pressure of the spinal fluid can be increased by compression of the jugular veins, which produces a narrowing of the vein canal.

Therefore, patients suffering from chronic jugular phlebitis already have an increased pressure in the spinal fluid before the onset of poliomyelitis and are more likely to develop extensive damage of the nervous tissue than those whose pressure is normal, because the power of resistance of the tissue has been weakened. Furthermore, persons suffering from increased pressure are more likely to succumb to poliomyelitis than others; and it is assumed that the relief of increased pressure in the spinal fluid may prevent the outbreak of poliomyelitis.

For these reasons I suggested removal of the concealed jugular phlebitis as the first step in treating poliomyelitis. I know of only one physician who followed my suggestion, a country doctor in Europe. He reported excellent results, especially with regard to preventing paralysis, if the treatment was given at the beginning of the disease. I saw in his small hospital a young girl suffering from poliomyelitis who had already developed paralysis. She responded very favorably to this simple and inexpensive treatment, and the paralysis improved considerably. Of course the number of his patients was comparatively small, but it should be very easy to treat many patients in this manner dur-

ing one of the seasonal epidemics. Then, on the basis of the results, the effectiveness of this treatment can be objectively decided. In the last analysis the art of healing is based upon observation. There are few more pregnant statements than Virgil's: *Experto credite!* (Believe one who has tried it!)

Naturally, the treatment must be started in the very first stages of the disease, possibly in the pre-paralytic stage. A paralysis generally indicates a severe affection of nerve tissue which may already be beyond repair. As soon as the diagnosis of poliomyelitis in an epidemic has been definitely established, it is imperative to treat patients as soon as possible who complain about fever and stiffness of the neck. My treatment has proved that it fulfills the two most important conditions for any treatment: it does no harm, and it shows results. Besides, the treatment is so elementary that any physician can apply it.

Infantile paralysis can be prevented, apparently, by removal of the infection in the jugular veins, if the treatment of poliomyelitis is commenced in time, before a destruction of the nerve tissue has set in. The individual case need not be abandoned to fatalistic inactivity.

CONCLUSION

In poliomyelitis the damage to the nervous tissue in the spinal cord is due in part to the increased pressure in the spinal fluid.

The increased pressure reduces the power of resistance and recovery of the nervous tissue.

The increased pressure is in many cases caused by a concealed jugular phlebitis.

Therefore, the first step in treating poliomyelitis should be to determine whether or not the patient suffers from concealed jugular phlebitis, and, if so, to remove this condition without delay.

CHAPTER XI

TREATMENT OF FOCAL INFECTION

The real problem of treating focal infection successfully resolves itself into the finding and eradicating of all the foci in the body. Obviously, it would be useless to remove one source of toxins and leave another which would continue to poison the body. Since the majority of focal infections are located in the tonsils, teeth, and veins, I shall discuss the treatment of foci in these three spots because it would be impossible to discuss the eradication of all possible focal infections in a book of this type. It must be clearly understood, however, that these are not the only possible locations of foci, and that the physician must make sure that no toxin factory in the body is overlooked. For, as Professor Thoma of Harvard University states in his book: *Oral Pathology* on page 764: "Eradication of infection should always be practiced for the sake of prevention, no matter what the condition of the patient; but in patients susceptible to diseases of the focal infec-

tious type, no focus of infection that can be removed should be tolerated."

Whenever the existence of a focal infection is suspected, the tonsils, teeth, and veins of the leg and neck (jugular veins), should be examined immediately to determine the seat of the infection.

Diseased tonsils should be radically removed. I have seldom seen a case in which the so-called conservative treatments, especially diathermy treatments, have been of any permanent help to the patient. Following such treatments there are often recurrences of infection and inflammation until a complete removal of the offending tonsils eliminates this focus completely.

Certainly it is unnecessary to emphasize the necessity for removing infected teeth. But it is impossible to repeat too frequently that dead or devitalized teeth are an even greater menace than obviously infected teeth because, since they often cause no pain at all, their action is much more insidious. Frequently dead teeth help to support bridgework which must be sacrificed in order to remove them. Generally speaking, however, these instances are much less frequent than formerly, since most dentists now recognize the danger of devitalized teeth and extract them rather than trying to preserve them through treatment and filling of the root canal. Even if a dead tooth does not cause any immediate trouble, sooner or later it will have to be removed. Therefore, it is much safer and more economical to have the tooth extracted as soon as it becomes

devitalized. The only reliable test to determine whether or not a tooth is alive is the "vitality" test. X-ray pictures do not always show whether the tooth is dead or not. The fact that dead teeth often do not cause pain or do not show signs of infection on the x-ray pictures gives the patients a false and dangerous sense of security.

Dr. Oliver T. Osborne, former Professor of Medicine at Yale University, writes as follows in his book, *What Everyone Ought to Know*:

"Every dead tooth is a menace, and a tooth dies because it is devitalized by a dentist, or from injury, or it dies from over-filling, by the metallic action of the substances used. If a tooth dies, its pulp canal putrifies and sooner or later this causes infection of the root.

"A dead tooth is always a menace and never can be considered safe after it has been dead for two months. Even when a tooth has been devitalized by a careful dentist and its canals have been filled for the purpose of preserving it from infection, still this tooth, as stated, after two months or more, when extracted and the canals opened and the tooth cultured in the laboratory, will generally be found to contain harmful germs.

"X-rays are now taken to decide the condition of the roots of teeth. If much inflammation is present or much degeneration has occurred, the x-ray will declare it. On the other hand, a tooth may have infection at the end of the root or in its canals and the x-ray picture does not show it. The x-ray picture can not show the

tooth has died unless an infective process has occurred at the root. (The x-ray can show deep pockets of infection down between the teeth where they cannot always be discovered by the dentist by simple observation.)

"If these infections at the root are shut in they may not show any symptoms on the gums, and frequently so-called 'prophylactic treatments' of cleaning the teeth and treating the gums may make the mouth appear healthy, while dead teeth, crowns, bridges, pivoted teeth, and poorly placed bridges may be carrying infection which is being absorbed into the body and doing harm. Some individuals are very susceptible to these germ poisons; others become tolerant to them and develop what may be termed an immunity, but this immunity is likely to break down when any disease or serious condition happens to the person, whether it be influenza, pneumonia, appendicitis, or some serious injury. In other words, these individuals are carrying around pieces of 'dynamite' that may at any time explode and cause more or less serious harm.

"All dead teeth must be extracted. There is no other safe procedure, and, at the present time, there is no known way to preserve an infected tooth, whether by treating the root, or cutting it off or by sterilizing it. These teeth must come out, and there is no such thing as the 'worst tooth'. A tooth that looks the worst in the x-ray picture may not cause as much harm to the

body as one that is dead but looks harmless in the picture."

This conception was confirmed on animal experiments which showed that in a healthy dog with healthy teeth, infection of the bloodstream (blood poisoning) may occur by infecting a tooth. A hole was drilled into a healthy tooth of the dog, the nerve was killed and the roots were infected with virulent germs. Several blood tests did not reveal an infection in the bloodstream as long as the tooth was left open. Then the root canal was "sterilized", and the hole in the tooth filled with cement. The same material and technique used by dentists was employed. Immediately after this procedure definite signs of infection of the bloodstream were found. It is evident from all this that *it takes a nerve to kill a nerve!* Lately I saw reports in a Swiss newspaper that a law will be introduced in Switzerland to forbid devitalizing of teeth.

Dr. John Drew, an English bacteriologist, says in his book: *Man, Microbe, and Malady* (Pelican Books) :

"It was the fashion some years ago among dental surgeons to devitalize a badly decayed tooth, fill the cavity with cement, and then crown the tooth with a gold cap. This treatment was based upon the fallacy that a dead natural tooth must be better than an artificial one. If, however, a tooth is so badly decayed that the pulp canal is involved, there is only one safe and effective treatment—extraction. It is almost impossible

for the most skillful dentist to fill the pulp canal of a tooth with a sterile filling. In most cases a colony of germs is left at the apex of the tooth after the pulp canal is filled, and from this focus there may be a steady, insidious absorption of bacterial toxins, sometimes with unfortunate effects on the individual."

After teeth and tonsils have been eliminated as sources of infection, the next step is to examine the veins, because very often an infection spreads from infected teeth and tonsils to the jugular and other veins. Focal infection in the veins is more frequently present than all other forms combined, in my opinion. Infection of the veins (phlebitis) is found most frequently in the veins of the legs or in the jugular veins (jugular phlebitis). The treatment varies with the seat of the infection.

TREATMENT OF CONGESTION OF THE HEAD

Congestion of the head can be treated successfully in only one way, namely, by removal of the jugular phlebitis that causes it. By curing the infection of the jugular veins we remove the congestion in the head, and thereby restore the defensive mechanism of the tissues in the affected area. Once the inflammation of the veins is removed, the swelling of the walls of the veins subsides, and the blood can flow freely from the head to the heart; the abnormal accumulation of venous

blood, that is, the congestion, in the region of the head is quickly removed and replaced by fresh arterial blood which supplies the tissues with oxygen and nourishing material. The restoration of normal circulation relieves the abnormal pressure in the head and removes accumulated poisonous waste material, thereby increasing the vitality of the affected tissues and their power to resist the damaging action of toxins. They can now combat successfully whichever disease is present, be it sinusitis, headaches or any of the conditions described in the preceding chapters. The diseased tissue, if not damaged beyond repair, will recover quickly and restore the normal texture of the chronically inflamed area.

The treatment of congestion of the head must take into consideration the fact that this condition is always caused by the jugular phlebitis. Therefore, to cure congestion of the head, the jugular phlebitis must be removed.

But this is not all. When the jugular veins are found to be affected, it is necessary to examine the teeth and tonsils and also the veins of the legs to find out whether or not the jugular phlebitis is an independent focus.

When no other focus is found in the body, and especially when teeth and tonsils are positively healthy, the jugular phlebitis should be treated immediately. But if diseased or devitalized teeth, or infected tonsils are present, then these organs should be removed be-

fore starting treatment of the jugular phlebitis. Otherwise, the foci in the mouth continue to reinfect the jugular veins.

If both the veins in the legs and the jugular veins are found to be infected, then whichever infection is more pronounced should be removed first, but the treatment of the other should be started as soon as possible, because the two infections can feed each other.

Diseased tonsils should always be radically removed. Only complete removal of the offending tonsils eliminates this primary focus.

It is hardly necessary to emphasize again the fact that infected teeth must be removed. But one cannot repeat often enough that dead or devitalized teeth are the greatest menace.

Oliver T. Osborne states in his book, *Mouth Infection*:

“For many years I was ridiculed for my viewpoint, and for my presumption in telling physicians they were neglecting their patients in not studying their mouths, and in not urging the complete eradication of active infection and of dead teeth. I was also frowned upon and actively opposed by dentists, when I presumed to order them to remove all infection from the mouth by extraction of teeth or by treatment, and when I stated that dead teeth were always a menace, and that it was inexcusable, if not almost malpractice, to devitalize a tooth, knowing the future menace to the patient, however well the canals might be filled.... Every ad-

vance in medicine, no matter in what department, has been at first ridiculed, from the time of Harvey's discovery of the circulation of the blood to the time that Oliver Wendell Holmes, of Boston, showed that child-bed fever was due to infection, and Semmelweiss, of Vienna showed that this infection was conveyed by dirty hands, until about twenty years ago, when the seriousness of mouth infection began to be discussed. Even up to fifteen years ago the writer was ridiculed by his confrères for insisting that dead teeth and neglected pyorrhea were serious matters, although he presented the proof; and it is only five years ago that a dentist was doubted by his fellows when he urged that complete sterilization of hands, instruments, etc., was a necessity before the extraction of teeth. . . . The dentist sees presumably well persons and has the opportunity to save more lives than the physician, as the physician rarely sees a person until he is ill."

It is safer and more economical to have a tooth extracted as soon as it becomes devitalized.

In treating a patient suffering from congestion of the head, therefore, it is necessary to examine not only the jugular veins, but also the whole body, and especially the teeth, tonsils, and the veins of the legs, in order to determine whether or not other foci exist in the body.

Before closing this chapter I want to point out that removal of jugular phlebitis will not only remove the congestion of the head and the diseases caused by

it, as, for example sinusitis, but it will also benefit the whole system and improve the general well-being of the patient. Not infrequently patients have reported to me a return of potency. For focal infection exerts its pernicious action of flooding the body with toxins, or germs, or both, by way of the bloodstream. Therefore, it produces a septic condition or septicemia, commonly known as blood poisoning. Jugular phlebitis, being an infection of a comparatively large portion of two large blood vessels and always involving the inner coat that is in direct contact with the blood, drains toxins directly into the bloodstream and, therefore, as a rule, gives rise to a more or less pronounced toxinemia long before the onset of a specific condition, as, for example, sinusitis or rheumatism.

Patients often ask how much time the treatment requires. The duration of the treatment depends on several factors. Of utmost importance is the constitution and vital resistance of a patient. A patient who has inherited a good constitution from healthy parents and grandparents has naturally a better chance of recovery than a patient in whose family run diseases like tuberculosis, syphilis, diabetes, etc.

Another important factor is the type of infection. My experience has been that, in patients who have suffered from typhoid fever, phlebitis generally responds slowly to treatment.

Naturally, the time element plays a great role in

infections. The recovery of a patient suffering from acute phlebitis is quicker than the recovery of a patient who had an infection in his veins for many years. If an infection has persisted in the body for twenty or thirty years, it has been firmly anchored to the tissues and cannot be dislodged in a few weeks. In these cases it may take a considerable period of time to effect a cure. Middle aged patients who had "growing pains" in their history respond more slowly to the treatment than patients who suffered from phlebitis only a short time.

As this book is written for laymen I shall not go into details about the treatment. Physicians who are interested in this subject will find descriptions of the treatment of phlebitis in my numerous scientific papers which have been published in many medical journals. (See *Index Medicus*, published by *The American Medical Association*.)

The treatment of every disease caused by focal infection must be aimed at the removal of every focus in the body.

Besides removal of infected teeth and tonsils it is necessary to examine the veins for a concealed infection (phlebitis).

If a concealed focus in the jugular veins or in the veins of the legs is overlooked and escapes treatment, the patient may find partial or temporary relief, but he will not recover his health.

SUMMARY

The focal infection theory postulates the idea that from a focus (breeding place of germs, point of origin of a disease) disease-producing germs or their toxins enter the bloodstream and produce symptoms of a disease somewhere else in the body. The focus, in the beginning, is a localized infection which in many cases causes no local symptoms at its site and therefore appears to be insignificant. But over a period of time this local infection may produce disturbances in organs remote from the original focus, the central seat of the disease.

The "Focal Infection Theory" was incomplete until the spreading mechanism of the infection was discovered. It has now been shown that focal infection causes a concealed infection in the veins. This infection in the veins produces a toxinemia (poisoning of the blood with bacterial toxins). Many diseases considered heretofore as independent local diseases are disorders resulting from the harmful action of toxins. Some diseases formerly thought of as clinical entities are only symptoms of focal infection. The physician must direct his interest to consideration of the real cause rather than the symptoms of a disease.

The focus is the chief center of a disease (morbid

process). Here the disease has its root and its inception.

When a patient takes ill, he directs all his attention to the outward symptoms of the disease and does not realize that the hidden cause may be in an entirely different part of the body. The disease symptoms are mostly due to the absorption of bacterial products (toxins) which are formed at a local source of infection.

The treatment of focal infection is specific because it is directed against the cause of a disease. It is obvious that this treatment is preferable to a symptomatic treatment in which the disease is left to its course and the symptoms are treated as they arrive.

The discovery of concealed infections in the veins explains the cause of many diseases for which there was no explanation before.

The etiology of allergy can now be clearly understood.

Future generations of physicians will be phlebitis-conscious and will realize how true the words of the great Cruveilhier were: "Phlebitis is at the root of all diseases".

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Physicians apparently never realized that Phlebitis constitutes a focus of infection. Every focus is a poison factory. The poison which is manufactured by the germ in the focus is distributed by the blood over the whole body and attacks those organs that cannot put up sufficient resistance. To cure a disease that is caused by focal infection, it is necessary to remove the poison factory which causes the symptoms. The focus which manufactures the poison often escapes medical treatment, because it is usually well hidden in the wall of an inflamed deep vein. It may exist for a long time before producing enough poison to attack an organ at a distant part of the body. But the patient mistakenly dates the onset of his disease from the moment when the attacked organ reacts with pain, swelling, or other signs of an abnormal condition.

The author of this book, Dr. Otto Meyer, of New York, has delved thoroughly into the problem of Phlebitis and is considered the foremost Phlebologist of our time. He is the discoverer of the latent (concealed) form of Phlebitis and has described the diagnosis, symptoms and treatment in more than fifty scientific papers. His description of latent Phlebitis was so accurate that several authors have quoted his observations nearly verbatim. Dr. Meyer has originated the word "*phlebotropism*" which expresses the affinity of disease-producing germs for the veins. He has introduced the terms "Phlebitic ulcer" and "Phlebitic eczema". He was the first to discover the concealed infection in the jugular veins which is in most cases caused by infection in the oral cavity (teeth, tonsils). He considers the concealed infection in the jugular veins the missing link in the focal infection theory. He explains why removal of infected teeth or tonsils is often not sufficient to heal a disease.

A great philosopher once said that most discoveries have to pass 3 steps: ridicule, arguments, general acceptance.

Dr. Meyer's revolutionary idea is in the second step. It is hoped that the third will be reached soon.

